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Third Party Liability Workshop Papers

May 22–24, 1979
June 19–21, 1979

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U.S. Department of Health, Education, and Welfare
Health Care Financing Administration

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1979

THIRD PARTY LIABILITY WORKSHOP PAPERS

May 22-24, 1979
St. Louis, Missouri

June 19-21, 1979
Richmond, Virginia

Department of Health, Education, and Welfare

Health Care Financing Administration

Medicaid/Medicare Management Institute

TABLE OF CONTENTS

PAGE

PREFACE 1

SUMMARIZED AGENDA 3

FEDERAL OVERVIEW 9

James C. Morant
Chief, Project Management Staff
Corrective Action Projects Division

Ben Holmes
Program Analyst
Corrective Action Projects Division

NORTH CAROLINA THIRD PARTY BENEFIT RECOVERY 19

Donald Best
Chief, Third Party Recovery Section
North Carolina Division of Medical Assistance

MINNESOTA THIRD PARTY BENEFIT RECOVERY 35

Beth Wahtera
Manager, Benefit Recovery Unit
Minnesota Department of Public Welfare

BLUE CROSS/BLUE SHIELD 49

Charles Tomek
Director, Plan Performance Division
Blue Cross/Blue Shield

HEALTH INSURANCE ASSOCIATION OF AMERICA 67

James F. Sullivan
Director, Group Claims Department
Aetna Life and Casualty

MEDICARE/MEDICAID CROSSOVER CLAIMS 75

Charles Smith
Methods and Procedures Analyst
Bureau of Program Operations
Health Care Financing Administration

CIVILIAN HEALTH AND MEDICAL PROGRAM
FOR THE UNIFORMED SERVICES (CHAMPUS) 83

Thomas Osoba
Chief, Program Policy Branch
Department of Defense

TABLE OF CONTENTS

PAGE

DATA COLLECTION AND PROVIDER RELATIONS 101

Steve McClain
Assistant Project Manager
Systems Architects, Inc.

QUALITY CONTROL 111

Michael Skutar
Manager, TPL/Quality Control
Michigan Department of Social Services

BUDGETING FOR TPL 125

Fred Sapetti
Chief, Bureau of Claims Processing
Illinois Department of Public Aid

Stephen Harrison
Chief, Third Party Liability Unit
California Department of Health Services

PROVIDER RELATIONSHIP AND EDUCATION 143
IV-D ABSENT PARENT

Russ Ward
Supervisor, Third Party Liability
Washington Department of Social and Health Services

TPL GENERAL SYSTEMS DESIGN 153

Michael Donley
Chief, MAMIS Division
Pennsylvania Department of Public Welfare

CASUALTY 165

Jerome Hansen
Chief, Recovery Section
California Department of Benefit Payments

PROBATE 173

Frank Traglia
Chief, Division of Medical Assistance Recovery
Maryland Department of Health and Mental Hygiene

TABLE OF CONTENTS

PAGE

ACCOUNTING AND FINANCE 193

Michael Clurman
Medical/Economics Specialist
Systems Architects, Inc.

WORKSHOP PARTICIPANTS 199

PREFACE

Third party benefit recovery, or third party liability (TPL), is of increasing importance to not only HCFA's Medicaid program, but also to all concerned with the rising costs of public health programs. Broadly speaking, third party benefit recovery refers to the responsibility of State agencies to recover resources due the Medicaid program, from sources as diverse as worker's compensation, commercial insurance plans, Medicare, or tort recoveries. These varied resources must not only be identified, but tapped when a Medicaid recipient has received medical services, payment for which is the contractual responsibility of a third party. Third party benefit recovery is mandated by Federal Statute (1902 (a) (25) of Title XIX of the Social Security Act). In essence, this statute requires that the Medicaid program will "pay the last dollar" when legal liability exists on the part of others to pay for care and services given a Medicaid recipient. Final regulations on TPL in Medicaid were published February 11, 1980 in the Federal Register.

Under the auspices of HCFA's Corrective Action Projects Division (CAPD)* of the Medicaid/Medicare Management Institute, two conferences on third party liability were held in 1979. One workshop (May 22-24) was held in St. Louis; the other (June 19-21) was held in Richmond, Va. Systems Architects, Inc., a contractor for CAPD, worked with that group in developing and conducting the workshops.

The purpose of the workshops was to provide training to States, to allow them to exchange information on third party benefit recovery. The meetings were designed to advise States on how to expand their TPL systems.

The workshops were well attended. Forty State and Federal employees took part in the St. Louis meeting, with 18 States represented; 68 State and Federal employees attended the Richmond workshop, with 20 States represented.

Topics covered during the meetings were: North Carolina's and Minnesota's third party benefit recovery operations, Blue Cross/Blue Shield plans, Health Insurance Association of America role, Medicare/Medicaid "crossover claims", Civilian Health and Medical Program for Uniformed Services (CHAMPUS), Veterans Administration - (St. Louis workshop only), "TPL Guide" priorities when establishing a TPL system: parameters of program performance, data collection, provider relationship and education, TPL general systems design, third party liability unit, accounting and finance: tracking and accounts receivable, and reporting requirements under HCFA-64.9.

There were also four workshops which covered quality control, IV-D as a third party benefit recovery source, budgeting for TPL, and probate/casualty.

This particular report is a compilation of presentations made at the Richmond workshop. Also included is a summarized agenda, and a list of participants for both workshops.

As part of its contract with CAPD, Systems Architects, Inc. is currently developing a how-to-do-it guide. This guide will lay out minimum criteria for establishing TPL systems and a number of options for completing this, and could serve as a good source document for States that are just getting their TPL efforts underway. That guide will be published later by the Institute.

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* Formerly, CAP was a focused effort within the old Medicaid Bureau, which was abolished when HCFA was reorganized in June, 1979. It is now a division of the Institute.

SUMMARIZED AGENDA

PRESENTATION	SPEAKERS
WELCOME, INTRODUCTION, AND FEDERAL OVERVIEW	James Morant, Chief Project Management Staff Corrective Action Projects Division DHEW/HCFA/BPO/MMMI Baltimore, Maryland AND Benjamin Holmes, Program Analyst Corrective Action Projects Division DHEW/HCFA/BPO/MMMI Baltimore, Maryland (Richmond only)
NORTH CAROLINA'S PRESENTATION	Donald Best, Chief Third Party Recovery Section Division of Medical Assistance Raleigh, North Carolina
MINNESOTA'S PRESENTATION	Beth Wahtera, Manager Benefit Recovery Unit Department of Public Welfare St. Paul, Minnesota
BLUE CROSS/BLUE SHIELD	Charles Tomek, Director Plan Performance Division Blue Cross and Blue Shield Associates Chicago, Illinois
HEALTH INSURANCE ASSOCIATION OF AMERICA	Donald Hankin, Senior Vice President Occidental Life Insurance Company Los Angeles, California (St. Louis only) James Sullivan, Director Group Claim Department Aetna Life and Casualty Company Hartford, Connecticut (Richmond only)
MEDICARE/MEDICAID "CROSSOVER CLAIMS"	Charles Smith, Methods and Procedures Analyst DHEW/HCFA/BPO Baltimore, Maryland

SUMMARIZED AGENDA

PRESENTATION		SPEAKERS
CIVILIAN HEALTH AND MEDICAL PROGRAM FOR THE UNIFORMED SERVICES (CHAMPUS)		Joseph Rhea, Chief of Program Planning and Development OCHAMPUS Denver, Colorado (St. Louis only)
		Thomas Osoba, Chief of Program Policy Branch Department of Defense, OCHAMPUS Denver, Colorado (Richmond only)
VETERANS ADMINISTRATION		Joseph Fleckenstein, Chief of Policy and Procedures Division Veterans Administration Central Office Washington, DC (St. Louis only)
INTRODUCTION - "HOW TO DO IT - TPL GUIDE"	Moderator:	Michael Clurman, Medical/Economics Specialist Systems Architects, Inc. (SAI) Randolph, Massachusetts
DATA COLLECTION	Moderator:	Steve McClain, Assistant Project Manager Systems Architects, Inc. (SAI) Arlington, Virginia
	Resources:	Michael Skutar, Manager TPL/Quality Control Michigan Department of Social Services Lansing, Michigan
		Fred Sapetti, Chief Bureau of Claims Processing Illinois Department of Public Aid Springfield, Illinois
		Steven Harrison, Chief Third Party Liability Unit Recovery Section Sacramento, California
		Michael Donley, Division Chief MAMIS Division Department of Public Welfare Harrisburg, Pennsylvania

SUMMARIZED AGENDA

PRESENTATION		SPEAKERS
PROVIDER RELATIONSHIP AND EDUCATION	Moderator:	Steve McClain
	Resources:	Russ Ward, Supervisor Third Party Liability Olympia, Washington
		Jerome Hansen, Chief Recovery Section Department of Benefit Payments Sacramento, California
		Michael Skutar
		Fred Sapetti
TPL GENERAL SYSTEMS DESIGN		Don Allen, Chief Systems Assistance Branch Corrective Action Projects Division DHEW/HCFA/BPO/MMMI Baltimore, Maryland
		Frank Yake, Chief of TPL Unit Office of Medical Assistance Department of Public Welfare Harrisburg, Pennsylvania (St. Louis only)
		Michael Donley (Richmond only)
	Resources:	Steven Harrison
		Michael Skutar
		Fred Sapetti

SUMMARIZED AGENDA

PRESENTATION		SPEAKERS
THIRD PARTY LIABILITY UNIT	Moderator:	Jack Scirappa Systems Architects, Inc. (SAI) Randolph, Massachussetts
	Resources:	Jerome Hansen
		Frank Traglia, Chief Division of Medical Assistance Recovery Maryland Department of Health and Mental Hygiene Baltimore, Maryland
		Russ Ward
		Michael Skutar
		Beth Wahtera
ACCOUNTING AND FINANCE	Moderator:	Michael Clurman
	Resources:	Stephen Harrison
		Beth Wahtera
		Jerome Hansen
REPORTING REQUIREMENTS UNDER HCFA-64.9		Nancy Drucker, Program Analyst DHEW/HCFA/BQC Baltimore, Maryland (Richmond only)
		Martin Gilbert, Grants Fiscal Management Specialist DHEW/HCFA/BPO Baltimore, Maryland (Richmond only)
		Bill Mulligan, Grants Fiscal Management Specialist DHEW/HCFA/BPO Baltimore, Maryland (Richmond only)
		Norman Kahn, Auditor DHEW/HCFA/Medicaid New York, New York (Richmond only)

SUMMARIZED AGENDA

PRESENTATION	SPEAKERS
CONCURRENT WORKSHOP SESSIONS	
WORKSHOP I - QUALITY CONTROL	Michael Skutar
WORKSHOP II - IV-D	Russ Ward
WORKSHOP III - BUDGETING FOR TPL	Fred Sapetti Stephen Harrison
WORKSHOP IV - PROBATE/CASUALTY	Frank Traglia Jerome Hansen
GENERAL SESSION	
CAPD AND STATE COOPERATIVE EFFORTS TO BUILD AN EFFECTIVE TPL PROGRAM	Michael Donley Fred Sapetti
CLOSING REMARKS	James Morant

FEDERAL OVERVIEW

James C. Morant
Chief, Project Management Staff

Ben Holmes
Program Analyst

Corrective Action Projects Division

Health Care Financing Administration

James C. Morant:

The general purposes of this conference are to provide training to States to allow them to exchange information on third party liability and to give them some advice on how to expand their system. This is a timely conference because of the Department of HEW's commitment to reduce fraud, abuse and waste. During the course of this conference, we want to go from the very general to the very specific. We would like to spend the first day going over the basic statutory requirements, expanding upon their discussion by explaining the characteristics of an automated TPL system and what a manually operated TPL system would be like. We want to talk about some of the possible resources that are available through insurance companies, through CHAMPUS. We also have faculty drawn from Medicaid State agencies, who will be available in the afternoon if you would like additional discussion or advice. The last two days will be devoted to detailed discussions of selected aspects of TPL operations, such as data collection, provider relations, systems enhancements, and Federal reporting requirements.

During November of 1978, a group of State representatives came to HEW and suggested that we put on some TPL conferences. We knew there had been about six of them two years ago, but the issue is heating up, and we decided to call some State folks in and try to figure out what they thought would be useful to talk to other State folks about in terms of TPL. That's basically how we developed this agenda. CAPD also contracted with Systems Architects to develop a TPL how-to-do-it guide. We also worked on trying to determine the policy voids which exist in TPL legislation and regulations, and we are working on trying to make some improvements on that.

I would like to read something to you from Medicaid third party benefit recovery, a document issued in 1977 on the Minnesota system. The analysis of that system led to several major conclusions, the most cogent of which was that "the legal authority for the benefit recovery activity exists in loose form at the Federal level, leaving the States to their own devices to develop firm legal foundations on which to base benefit recovery activities. This has led to inactivity of several States, or, at best, a large State effort in developing procedures and organizations, and defining and obtaining the necessary legislation to facilitate benefit recovery." TPL has been on the books since Medicaid was enacted. Since March 31, 1968, States have been required to take "reasonable" measures to ascertain legal liabilities for the third parties. Well, almost eleven years and three months to the day, we are here examining what those <u>reasonable measures should be</u>.

I must say that we from HEW and those of you from Medicaid State agencies must be highly commended for the speed, vigor and sense of urgency with which we have pursued this most important program issue. I am not sure whether it took a new administration, new legislation, a new organizational structure, a new HEW Secretary, or all of the above, to draw attention to this issue. However, I do feel, as I'm sure you might, some genuine pressure and concern on the part of a number of individuals and groups to make more progress.

I'd like to try to set some legislative parameters for why this is an important issue and try to describe what the statutory base is, and where we are on regulations.

The statutory base for TPL activity is contained in Section 1902(a)25 of the Social Security Act. This section states that a State plan will provide that the State or local agency administering such a plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan. Then it goes on to say that where the State or local agency knows that a third party has such a legal liability, such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available. That in any case where a legal liability is found to exist after medical assistance has been made available, the State or local agency will seek reimbursement for such assistance to the extent of such visible legal liability. The regulatory requirements which implement that are contained in our Code of Federal Regulations 42 CFR 433.135. Public Law 95-142, which came into existence October, 1977, added another section, Section 1912, which also has TPL relevance. Ben Holmes of my staff will make a presentation of what Section 1912 will actually mean to us. He was the principal drafter of the current regulations.

With that as a general framework, I would like to begin to talk about who might be interested in TPL. There are several interested entities I will go into first because that is what I am most familiar with. The Inspector General's Office is interested and is developing an audit guide to assess identification of TPL resources and to evaluate collection activities in States. It has targeted in its work plans a number of States to be further examined. Virginia was supposed to be the test site for the Inspector General's activities and pending successful completion of that test, they were then going to go to one State in each region to take a look at this in some more detail.

So, the Inspector General's Office is interested and, the Social Security Administration is vitally interested. We have to work with Social Security in establishing Medicaid eligibility and they are our partners in a number of instances. Another unit in HEW which is most interested in TPL is HCFA, and it's interested from a number of different perspectives. It's interested because it's a legislative mandate and we have to implement that legislative mandate. We have policies that need to be pursued. Our quality control unit is interested for data collection purposes and for trying to assess what penalties, if any, should be applied in terms of TPL. The Corrective Action Projects Division, of which I'm a part, is vitally interested in TPL because one of our charges is to try, to every extent that we can, to render technical assistance to States to improve TPL capabilities. We have a staff of about 30 folks and what we do is send teams to States and try to camp out with them for as long as necessary, one week, two weeks for detailed technical assistance. Our projects run an average of 3 or 4 months and what we ask is that the State make as much of an investment in their improvement as we do. We will put up X amount of staff and we ask the State to do the same thing. We work much as a management consulting firm would. We produce deliverables based on a time frame designated by the State or as negotiated between us and the State. Those are the interested HEW parties.

Other entities who are interested in TPL are Congress, the Senate Finance Committee, the House Ways and Means Committee, and the House Interstate and Foreign Commerce Committee. All had jurisdiction over the development of Public Law 95-142, which strengthened the legislative base for TPL and also provided some impetus for doing more. The General Accounting Office was commissioned by Congress a couple of years ago to do a study on

third party liability. So they will always be keeping a watchful eye over third party liability activity.

Another entity interested in what happens with TPL, is the Health Insurance Association of America. We have some representatives who will be speaking to you this afternoon on their interests on this very important matter. Blue Cross/Blue Shield, represented by Chuck Tomek, is interested in TPL activities because TPL will have an impact on all the health insurance industry in terms of their benefits that are available. Medicaid State agencies are always interested in trying to figure out how they can maximize their dollar. State legislatures are also interested. You will be getting pressure from other organizational components as well as your own State legislatures to try to come up with some savings ideas. And, finally, the most forgotten person is the recipient and the taxpayer. I'm interested in having my taxes reduced. I would like to see all the Federal bucks go for what's needed and what's useful. And so I'm going to be interested in what happens in terms of recoveries from other parties, so that I don't have to contribute as much to the Federal bureaucracy, if you will. So those are the kinds of people that are going to be involved. That is your general overview of what the impact of your operation touches.

I would like to go into now where the Feds currently are. This is going to be a little muddy because for several weeks, we've been doing a lot of work in trying to figure out how we collect information on third party liability savings, working with statistics we have available inhouse and coming up with reasonable targets for savings in FY 79 and FY 80. Our FY 79 savings figure for third party recoveries is $77 million.

We figure that if States pursue third party vigorously, a minimum amount we could save would be $77 million. So that's a major Departmental initiative to reduce fraud, abuse and waste.

The other thing that is happening in HCFA, which will have some impact on the operation, is a major reorganization which is taking place. In fact, you all have the distinction of attending the last conference to be held under the auspices of the Medicaid Bureau. The Medicaid Bureau goes out of existence tomorrow. What has been created instead are five major bureaus in the Health Care Financing Administration. There used to be a Medicaid Bureau, a Medicare Bureau, and a number of staff offices. What is now going to be created is five bureaus: a Bureau of Policy, a Bureau of Support Services, a Bureau of Program Operations, a Bureau of Quality Control, and a Health Standards and Quality Bureau.

There will also be a staff on Intergovernmental Affairs whom you will probably have to interact with at some time. The idea of the reorganization is to integrate, where possible, the administrative functions of Medicare and Medicaid. The theory behind this is to streamline operations and hopefully lead to improved efficiency in management.

The other thing that is going on is the development of the implementing regulations for Section 1912. The principle provision of that regulation is that States will be permitted, as a condition of eligibility, to require an assignment of benefits from recipients. Section 1912 permits cooperative agreements between localities and permits incentive payments to States for recovery activity. It prohibits Federal matching for insurance benefits that

have exclusionary clauses and it also permits pay and chase or cost avoidance type of TPL recovery. Ben Holmes will describe these regulations. He's been a major actor in collecting the comments which came from various State agencies, legislative bodies, lobby groups, whatever. We've identified 12 or 13 issues that need to be addressed and which we will be addressing in the coming months, reorganization or not, so I will ask Ben to come forward now.

Thank you very much.

Ben Holmes:

I sort of consider myself a State person since I was employed with the State of Maryland about 20 years until approximately eight months ago, when I decided the only way to resolve a problem and its issues would be to come work for the Feds. So that's why I left Maryland.

I do welcome the opportunity to get your comments on the regulations. As a former State person, I know how you feel sometimes when you receive the new regulations and say "Gee, what nut thought this up," or "how is this going to work?" We have a draft regulation in each package. I realize you have not had an opportunity to review it, but I will be here all three days, and I would like to get your reactions and questions some time during the session. Jim asked me to talk about some of the things we did resolve, so I will begin on that point.

We issued a proposed rule on August 29, 1978.* We received approximately 30 responses from such agencies as State welfare and Medicaid agencies, State child support enforcement agencies, advocates for the disadvantaged, attorneys for medical service providers, hospitals, and the Department of Interior. In addition, we have had several meetings with the Health Insurance Association of America and other representatives of the health insurance industry. What we did, of course, was to revise the final regulation, based on comments received from the States and others I just named. One comment I've recommended is to change the definition of a private insured to include all types of self-insurance in trust administered by the U.S. Department of Labor. Some of the large labor unions have self-insurance for their memberships. This suggestion was consistent with HEW's goals of maximizing use of third party resources. The regulations at 433.135 have been changed accordingly.

Seven commenters were concerned that the regulations would reduce total reimbursement to institutional providers by changing the normal claims payment procedure among insurance companies, State agencies and Medicaid. The confusion was based on lack of understanding of the difference between the assignment of benefits and the payment of claims. They are basically two separate issues. The final regulations authorized two basic methods for claims payment which agencies may use. The first one is direct billing to the third party by providers, and billing the agency for amounts not covered by the third party. The second is payment to the provider by the agency with reimbursement obtained from the third party. The former method is called direct billing or cost avoidance. The latter method, called pay and chase, results in prompter payments to providers. This is particularly important for solo and small group providers, because they usually lack the clerical resources for billing the various companies. Direct billing results in somewhat larger payments to providers because insurance companies pay claims on the basis of charges rather than costs.

Institutions are better staffed for claims processing and, as a result, favor direct negotiations with the third parties. Since the intent of this regulation is to assure utilization of available third party resources of Medicaid patients, States may use either method of payment or even a combination.

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* Final regulations on TPL in Medicaid were published February 11, 1980 in the Federal Register.

The next requirement is an interesting point and is related to timing. If the State chooses to pay the provider before seeking reimbursement from a liable third party, it must seek reimbursement within 30 days after the end of the month in which payment is made. In those instances when a State agency does not know of the existence of the liable third party when a claim is paid, the State must seek reimbursement from the third party within 45 days of learning of its liability. These time frames will insure that the intent of the regulation is met within reasonable and/or sufficient time to allow the State to take the necessary steps to obtain reimbursement.

When you receive comments in response to proposed regulations, you usually receive them from the opposite ends of a spectrum. On one hand, you receive comments from States that you are being too liberal. On the other hand, you receive comments from opposite groups saying you are being too restrictive. So you see that we had to respond to both ends of the spectrum on the comments. In relation to timely payment of claims, one hospital and one State hospital association requested that States pay claims more quickly. Timely payment of "clean" claims, those that require no additional clarification, is required by Section 2(b) of Public Law 95-142. Therefore, we did not have to address this in the regulations. HCFA did publish regulations on this requirement, but these were published on August 18th and were not in relation to the TPL regulations.

Next we will get to one of the more controversial issues. That's the refund of excess collections. A health insurance group objected to refunding to the individual any amount remaining after third parties reimburse the Medicaid agency. This overage occurs when providers are paid by the agency at State rates, and reimbursement is obtained from third parties, usually at a higher rate, based on charges. We had no choice in this. The statute is very clear that any overage must be paid to the individual. The recipient of Medicaid is the individual. The statute says it must be the Medicaid recipient that gets the overage.

The next issue is also a controversial one - the varying rates of FFP and third party recoveries. Nine State Medicaid or welfare agencies and one State attorney general pointed out the problem created for States by varying rates of FFP for Medicaid recovery work. The FFP rate for Medicaid is 50% while the FFP for Title IV-D is 75%. Now it is obvious what could happen in States. They probably would emphasize the IV-D recovery, while minimizing Medicaid because of this discrepancy. We are aware of this and we are going to propose a legislative remedy to change this. Right now, of course, this is in the Act - the Federal matching formula. We can't change it through regulations, but we are going to propose legislation to effect a change.

Good cause for failure to cooperate - three State health or welfare agencies and two legal advocacy groups for the poor presented comments on the "good cause" issue. Good cause for refusal to cooperate in establishing paternity or obtaining medical support and payments exist, if it is anticipated that cooperation will result in possible reprisal, such as physical or emotional harm to the individual or child. HEW held lengthy hearings and obtained numerous written comments on this issue, in response to a similar rule developed by the Office of Child Support. The notice of proposed rulemaking specified procedures for Medicaid agencies to follow in waiving cooperation that differed from policies followed in AFDC. We have responded to the good cause comments by adopting for Medicaid essentially

the same policies followed in AFDC, with necessary adjustments for medical support. One of the State agencies was concerned that services would not be available for an unborn child, because of the failure of the mother to cooperate in establishing paternity or obtaining medical care support. The third party liability regulations published do not deal with Medicaid eligibility for services for unborn children. A coverage group is treated in accordance with a State's Medicaid plan.

Approximately three-fifths of the States have agreements with the Social Security Administration, under Section 1634 of the Act, for SSA to determine Medicaid eligibility for persons who are eligible for cash assistance under the Supplemental Security Income program for the aged, blind and disabled. Five States expressed concern that these agreements may be cancelled by SSA, since the conditions of the agreement prohibit the imposition of any additional eligibility requirements such as assignment of benefits. HCFA and SSA are discussing this question and I will report on this a little later on. We are making progress in this area. Final regulations, which I've just given you comments on, have been drafted and are presently undergoing review by General Counsel and other parts of our agency. We do expect that those regulations will be published within two to three months.

There are some issues that have not been resolved by the regulations. I think we ought to discuss these. The first is the need to amend regulations to permit assignments in 1634 States. As you are aware, Section 11 did not amend Title XVI, it amended Title XIX by adding a new section. Consequently, there appeared to be some conflicting opinion as to whether or not we could require assignments from SSI or even AFDC eligibles. We did receive an opinion from our General Counsel which said that a State had the right to require an assignment from every Medicaid recipient, including AFDC recipients, so this issue has been fairly well resolved. We have been working with the Social Security Administration and they have initiated a change in their regulations which permit assignments by 1634 States. At this point, we don't foresee any conflict with the Social Security Administration and those 1634 States that choose to require assignment as a condition of eligibility. The next item is a revision of the 1634 agreements. It's fairly obvious that if you're going to require an assignment, that you would have to revise your 1634 agreement. Action has already been started on this by the Social Security Administration.

The next item is the collection of TPL data from SSA recipients in 1634 States. This has been a problem going back for a number of years now. States have repeatedly indicated that the TPL data fields should be expanded. Basically, now you only have a yes or no indicator which really doesn't tell you very much. There is a task force of staff from Social Security and HCFA looking at this problem. One of the things we plan to do is to survey the States to see what information you would need from SSI eligibles and would be willing to pay for. Social Security is looking at the possibility of collecting the information in the 1634 States.

Next is the mandatory collection of social security numbers. You really need the social security number for BENDEX and for many other TPL related activities. The States can't require use of the number if the requirement was not in effect prior to January, 1975. For States not having the requirement prior to '75, a signed consent from the applicant/recipient must be obtained. You cannot deny eligibility if they fail to give you this

consent. Now, of course, the remedy is legislation and we do plan to seek legislation by 1981 to correct this.

Next is the use of Title XIX data for programs. Right now we have a requirement that says that any information collected for Title XIX basically can only be used for Title XIX. We would like to liberalize this, as in Title IV-A and some of the other Federal Titles, so that the data can be used by other programs, as long as you protect the rights of confidentiality. We do plan to try to seek legislation to correct this. Next is the use of IRS data. At this point, we don't really know how helpful the use of IRS data would be for our program, but this is something we will be looking at and asking you, the States, if you feel that this kind of information would be helpful. Some of the other programs are using this kind of information. Title IV-D is using it to try to locate absent parents. We don't know just how helpful it is going to be in Medicaid - this is one of the points we intend to pursue within the next 12 months.

Next, timeliness and accuracy of Medicare determinations - we found that one of the problems we have had is that the accuracy of Medicare determinations has not been the best. Also, the determinations have not been done in a timely fashion, which, of course, means that you miss the third party resource. We intend to pursue this to see if there is some way that we can increase the accuracy and timeliness of the Medicare determinations.

The last item is the use of wage record data. Maryland had used this in the IV-A program. You can use records from the employment security file to check if there are unreported earnings. We don't know if this is going to be helpful to the Medicaid program, but CAPD is going to review after it has been used in the AFDC program. Again, this could be a potential resource for detecting unreported earnings. Thank you for your attention. I'll be happy to take any questions, now.

NORTH CAROLINA

THIRD PARTY BENEFIT RECOVERY

Donald Best

Chief, Third Party Recovery Section

North Carolina Division of Medical Assistance

It's a pleasure for me to be here this morning to talk to you about third party recovery. As you know, this is one of the things that HEW is really into right now, among other things, so the more dollars we can get, the happier they're going to be. Hopefully they will let us do our own thing out there to a certain degree.

Our recovery section in North Carolina was created by the legislature in 1977. At that time, we were a part of the North Carolina Division of Social Services and we were authorized four staff positions. These were chief of third party recovery, two field investigators and a secretary. In January of 1978, when personnel were being hired, an additional field investigator was allotted to our unit. This unit was assigned to the medical services section, in the Division of Social Services, and had the responsibility of running the Medicaid program as far as policy, procedure, and claims processing were concerned. The Medicaid accounting unit was a part of the accounting section of the Division of Social Services and as such, came under the jurisdiction of the direction of Comptroller for the Division of Social Services, not the chief of medical services. At the same time a third party recovery section was being put together, three clerical positions were allotted to the Medicaid accounting unit to handle third party recovery. So you can see that we started out with duplicate effort.

We found ourselves with duplicate recovery files, and were writing insurance companies, attorneys, and providers in duplicate and sometimes contradictory letters. Originally the accounting unit TPL clerks were to handle only the receiving and disposition of the refunds. The medical services TPL unit was responsible for setting procedures. We also did an investigation of possible TPL on submitted and paid claims and the actual negotiation with attorneys and insurance companies. Due to the physical arrangement of the two units within the Division of Social Services, the communications with each other was fair to good at best. Needless to say, it was not long before communication breakdowns started to occur.

Our overall TPL efforts suffered because of the separation and breakdown of communications. At about this same time, a management team, contracted by the State legislature to study the Medicaid program and its operations, made a report. They recommended that the Medicaid program be broken away from the Division of Social Services and a new Division of Medical Assistance be created to handle the Medicaid program entirely. The Secretary of the Department of Human Resources, the State umbrella agency, accepted these recommendations and the new division became active on July 1, 1978. With the new division, the third party recovery section was now one.

The new organization allotted a staff of a chief, two field investigators, one accountant, one accountant clerk, and a secretary. After the reorganization things started coming together for us. The new TPL section has the full responsibility of identification, investigation, collection, and accounting of all third party recovery funds. In addition, we have the responsibility of setting procedures, training necessary State and county personnel, and the distribution of procedures and information concerning TPL to other State agencies, the local county Department of Social Services and the provider community. All of this is accomplished with only six staff persons. Needless to say, we stay busy.

The third party recovery section budget for the current fiscal year is approximately $120,000. I cannot give you an exact figure because our budget is broken down no further than the program integrity area, which includes third party recovery, utilization review, fraud and abuse and Medicaid quality control. The travel for our two field investigators around the State is approximately $1,000 per month, and our telephone bill runs $200-$300 per month. We handle many of our claims by correspondence and by telephone. The majority of the traveling is done for public relations and education workshops with the provider community, and with the various county Departments of Social Services.

Back in January and February of 1978, the staff had to decide what we were going to do with this thing called third party recovery, or third party liability. Our fiscal agency was already creating a TPL suspect list from the paid claims. Our eligibility files were carrying a yes/no indicator for health insurance and they were creating a suspect list for accidents based on diagnosis codes. A list of claims filed with a yes on the claim form is also put on the suspect list.

We used this as a starting point and decided the first source of information as to accidents and other health insurance lay with the provider. We then designed a system generated letter to be sent to the provider when the claim was paid to ask for any third party information they had. When these information letters were returned, if there was enough information, we then put the insurance companies or the attorney, whichever was appropriate, on notice. In the case of health insurance, we write the company involved requesting appropriate information from these return letters, then we contact the local county Department of Social Services and request that they contact the recipient and secure this information directly from them. Our counties cooperate and assist us in a very effective way. Since the counties in North Carolina participate financially in the Medicaid program, they are very helpful in assisting us in securing our refunds and our TPL information. This system after modification and changes, now appears to be working fairly successfully.

At the end of our first complete fiscal year (June 30, 1979), we will recover third party resources in excess of $5,000,000, not including Medicare. It is my opinion that there is between $15 and $20 million in North Carolina to be recovered annually from all sources, not including Medicare, so you see we still have a long way to go.

One of the most important things we are doing is redesigning our entire eligibility system. The new system will include all of the elements we will need for third party health insurance resources. This will be a subsystem to the major eligibility file. As an interim step, we are going with the yes/no indicator on our current eligibility file. We have the one element available in the system and we are going to use 36 codes in that one space. These codes will identify the primary health insurance carrier in North Carolina by name, on the recipient ID card. Included will be the indicator for Medicare Parts A and B, CHAMPUS, and combinations of these with private carriers. Our provider community is looking forward with enthusiasm to this interim change. We are looking forward to the day when our new system becomes operational, at which time we will be able to give the provider any TPL information they need to file a health insurance claim.

Our State legislature has given us two general statutes to operate under. One gives an individual county subrogation rights to all third party resources, contractual or otherwise, and also makes it a misdemeanor for the recipient to withhold any information concerning third party resources (Exhibit 1). The other general statute gives the State an assignment of benefits to third party resources (Exhibit 2). It took a while to make everyone concerned aware of these statutes, but we are now receiving tremendous cooperation from both the insurance industry and the legal profession. In addition to these two groups, the provider community has cooperated in every way it can to assist us. The cooperation between all concerned has been very commendable. We have not had a single case so far where an insurance company or an attorney has refused to reimburse the Medicaid program voluntarily.

We have three sources for collecting the data on possible third party recovery claims. First we have the diagnosis codes edit in the system that produces the TPL suspect list. These are many codes that are or can be related to an accident, such as fractures, lacerations, concussions, what have you. When a claim is submitted with one of these coded diagnoses, the claim is paid and is put on the suspect list. In addition, a third party information request letter (Exhibit 3) is sent to the provider that submitted the claim. This is our system generated letter. If there is a diagnosis related to an accident, the bottom block is checked and this letter goes back to the provider, and of course, it gives the provider all the information, across the top, that he/she will need to identify that particular case medical record number, the date the claim was paid, and what have you. If it is an accident, we ask the provider to fill out section B and give us as much information as he/she possibly can. This same letter is generated if there is a yes indicator on the eligibility file, but the provider does not indicate a health insurance payment or denial with the claim. The form is sent back to him/her with the top block X'd and they are asked to fill out section A. If we get the necessary information from this, then we go ahead and follow through. In the case of section B, if they do not have the information, and sometimes they don't, we then go back to the local department and ask them to follow up and get us the information about the accident, loss, who the insurance carrier is, who the attorney representing the recipient is, and so on.

The system automatically sends the letter out if the code is related to a trauma type case, or if the yes indicator is present and no insurance information, such as payment or denial, is shown on the claim form.

We have established a base of $50 as far as sending out these request letters. If payment of the claim submitted is less than $50, then this letter does not go out. When these letters are returned to us, as I said, we find all kinds of information and we do follow up whatever information is on them.

Second, I have furnished all hospitals in North Carolina with an accident form, and for those of you here from Virginia, you might recognize this (Exhibit 4). We kind of stole your form and redesigned it just a little bit to fit our situation. We have furnished this particular accident report form to each hospital in North Carolina and we have asked them to fill out this form and send it back to us immediately any time a person comes in as a result of an accident, and identifies themselves as a Medicaid recipient. We ask them not to hold it, in order to get that bottom information in this section

Exhibit 1

GENERAL ASSEMBLY OF NORTH CAROLINA
1973 SESSION (2nd SESSION, 1974)
RATIFIED BILL

OCT MAR 25 1974

CHAPTER 1031

HOUSE BILL 1228

AN ACT TO AMEND ARTICLE 2, PART 5 OF CHAPTER 108 OF THE GENERAL STATUTES, TO PROVIDE FOR RECOVERY FROM CERTAIN PERSONS FUNDS PAID FOR MEDICAL ASSISTANCE.

The General Assembly of North Carolina enacts:

Section 1. A new section is hereby added at the end of Article 2, Part 5 of Chapter 108 of the General Statutes, as follows:

"§ 108-61.2. Subrogation rights, withholding of information a misdemeanor.--(a) To the extent of payments under this Part, the county involved shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of assistance under this Part against any person. It shall be the responsibility of the county commissioners, with such cooperation as they shall require from the county board of social services and the county director of social services, to enforce this section through the services of the county attorney in accordance with attorneys' fee arrangements approved by the State Board of Social Services. The United States and the State of North Carolina shall be entitled to share in each net recovery under this section. Their shares shall be promptly paid under this section and their proportionate parts of such sum shall be determined in accordance with the matching formulas in use during the period for which assistance was paid to the recipient.

(b) It shall be a misdemeanor for any person seeking or having obtained assistance under this Part for himself or another to willfully fail to disclose to the county department of social services or its attorney the identity of any person or organization against whom the recipient of assistance has a right of recovery, contractual or otherwise."

Sec. 2. This act shall become effective October 1, 1974.

In the General Assembly read three times and ratified, this the 22nd day of March, 1974.

JAMES B. HUNT, JR.

James B. Hunt, Jr.
President of the Senate

JAMES E. RAMSEY

James E. Ramsey
Speaker of the House of Representatives

Exhibit 2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1977
RATIFIED BILL

MEDICAL RESOURCES
MAR 21 1978
SECTION

CHAPTER 664

SENATE BILL 847

AN ACT TO PROVIDE THAT THE ACCEPTANCE OF MEDICAID CONSTITUTES AN ASSIGNMENT TO THE STATE OF RIGHT TO THIRD PARTY INSURANCE BENEFITS AND TO PRESCRIBE PROCEDURE FOR RECOVERY OF SAID BENEFITS.

The General Assembly of North Carolina enacts:

Section 1. Part 5 of Article 2 of Chapter 108 of the General Statutes of North Carolina is hereby amended by adding a new section immediately following G.S. 108-61.2, to be numbered G.S. 108-61.4, and to read as follows:

"§ 108-61.4. Acceptance of medical assistance constitutes assignment to the State of right to third party insurance benefits; recovery procedure.--(a) By accepting medical assistance, the recipient shall be deemed to have made an assignment to the State of the right to third party insurance benefits to which he may be entitled.

(b) The responsible State agency shall disseminate the contents of this bill to all involved parties; the county government agencies, all Medicaid eligibles, all providers, and all insurance companies doing business in North Carolina.

(c) Since the ratio of dollars collected to State agency staff employed exceeds 10 to one, the responsible State agency will establish a third party resources collection unit that is adequate to assure maximum collection of third party resources.

Sec. 2. This act shall become effective upon ratification.

In the General Assembly read three times and ratified, this the 21st day of June, 1977.

JAMES C. GREEN, SR.

James C. Green

President of the Senate

CARL J. STEWART, JR.

Carl J. Stewart, Jr.

Speaker of the House of Representatives

Senate Bill 847

Exhibit 3

Please complete this form then return

DIVISION OF MEDICAL ASSISTANCE
THIRD PARTY RECOVERY SECTION
336 FAYETTEVILLE STREET MALL
RALEIGH, NORTH CAROLINA 27601

DATE: _____

_____
_____
_____

RE: Recipient: _____
Medicaid ID No.: _____
Date Paid by Medicaid: _____
Medicaid Claim No.: _____

Date(s) of Service: _____
Medical Record No.: _____
Amount Paid by Medicaid: _____

Third Party Indicators: Third party involvement indicated by:

____ State provided eligibility file indicates Health Insurance. (Complete Section A Below)

____ The claim you filed indicated an Insurance Payment had been made. Please indicate the source of payment _____
_____

____ The claim you submitted indicates patient may have been involved in an accident which may be covered by Auto, School, Workmen's compensation, etc. Insurance. (Complete Section B below)

*****REQUESTED THIRD PARTY FILING INFORMATION*****

SECTION A:

1. Did you file a claim with a health insurance carrier? Yes _____ No_____
2. Name of Health Insurance carrier: _____
   Policy no: _____ Certificate No: _____
3. What was the result of your filing? Paid _____ Denied _____
4. Amount Paid by Health Insurance carrier: $_____
5. Amount Paid by Medicaid: $_____
6. Send Refund Check for the lesser of amounts shown on lines 4 & 5.

SECTION B:

1. How did this accident occur? (auto, school, home, etc.) _____
2. Have you determined the name of Liability Insurance carrier? Yes _____ No _____
3. Have you received request for bill? Yes _____ No _____
4. If Yes: From Attorney _____ Insurance Carrier _____
5. Name and Address of Insurance Carrier _____
   _____
   Claim/Policy No. if known _____
6. Name and Address of Attorney: _____
   _____
7. Amount Paid, if any $_____ Medicaid Payment $ _____
8. Please refund the lesser amount shown on Line 7.

REFUND METHOD:

All refund checks must be payable to the Division of Medical Assistance and sent to the Third Party Recovery Section at the address shown above.

ATTACHMENTS:

Please attach a copy of this form to your refund check or denial.

Provider Signature_____ Title_____ Date_____

Exhibit 4

THIRD PARTY LIABILITY "ACCIDENT" INFORMATION REPORT

This form should be submitted to the North Carolina Medical Assistance Program as soon as possible after a service is rendered to a North Carolina Medicaid recipient for injuries attributable to an accident.

Statutory authority is provided for full recovery of funds from liable third parties in Chapter 108 of the General Statutes of North Carolina.

PLEASE PRINT OR TYPE

NAME OF RECIPIENT: _____
LAST FIRST MIDDLE INITIAL

RECIPIENT'S ID#: _____
PROGRAM COUNTY ACCOUNT NUMBER FAMILY NUMBER

LOCATION OF ACCIDENT: _____
COUNTY CITY

DATE OF ACCIDENT: _____ DATE SERVICE BEGAN: _____

TYPE OF ACCIDENT: _____ (AUTO, HOME, WORK RELATED, ETC.)

(COMPLETE TO BEST OF YOUR KNOWLEDGE)

NAME OF INSURED PERSON: _____

NAME OF INSURANCE COMPANY: _____

ADDRESS OF INSURANCE COMPANY: _____

POLICY NUMBER: _____ ACCIDENT CLAIM NUMBER: _____

NAME OF RECIPIENT'S ATTORNEY; IF ANY: _____

COMMENTS: _____

_____

NAME OF PROVIDER: _____

DATE: _____ PROVIDER NO.: _____

SUBMITTED BY: _____

Provider will not be involved in litigation attempts by the North Carolina Medicaid Program nor will reimbursement to the provider be withheld as a result of submitting this form.

North Carolina Department of Human Resources
Division of Medical Assistance
Third Party Recovery Section
Insurance Building
336 Fayetteville Street Mall
Raleigh, North Carolina 27601

here, but as long as they will give us the top information and anything in the second section that they might have, then we will take it and follow through with it. Of course, as all of you know, we need the date of the accident and where the accident occurred. From there we can go to DMV and get a copy of the police report and follow through on that. Just about everything we get from the provider goes on these reports, either auto accidents or some type of home accidents, but primarily they are auto accidents - that's where the dollars are.

Third, we also get information directly from the individual counties. They provide us with all the information that we need to secure refunds in a particular situation. These are accidents that the counties find out about either directly from the recipient or by checking the newspapers in the local area. In the first two situations, when the request letters from the providers or the accident report from the hospital do not give us the complete information that we need, we then go directly to the local counties, advise them of the accident, and request them to contact the recipient and secure the needed information to complete our file, so that we can pursue the third party recovery from the appropriate individual or insurance carrier. As I stated before, the county helps us gather this information because they are also financially interested in the recovery. Our counties participate in the Medicaid program in an amount of approximately 4 1/2%. This is the primary reason we get such cooperation from the counties in securing this much needed information. Once we get the names of the responsible individuals, insurance carriers or attorneys in these three situations, we put them on notice of the counties subrogation claim and the State's assignment of benefits. This is a letter that we use to put the insurance carrier on notice (Exhibit 5), advise of the general statute that gives the State the assignment of benefits, and what to do if the carrier receives a bill from the hospital or the doctor with the words "Medicaid Recipient and Benefits Assigned" stamped on it. We do allow them to pay the hospital or doctor directly, just let us know about it.

This essentially is the same letter as before (Exhibit 6), but this one is to the attorney setting forth the same thing, the State statute that gives us the assignment right. We do not quote the statute that gives the county subrogation rights. It is an entirely different statute, but if they do not want to cooperate with us and honor the assignment statute, then we will call the subrogation statute on them and get the county attorney involved to either file suit or do whatever is necessary to make believers out of them. After we notify the insurance carrier or the attorney, we then secure payment history profiles and begin to gather data pertaining only to the accident or illness involved. When this is done, we then record the amount of recovery that we are seeking in our accounts receivable and hence onto the Federal quarterly report on HCFA Form 64.9a. We keep all of our recovery files on a thirty to forty-five day suspense unless the insurance carrier or the attorney advises us along the way. We then suspend it for an appropriate time based on their suggestions. Prior to a final refund, we secure an updated payment profile to be sure we have all claims accounted for. We then furnish a complete listing of claims and the total amount of subrogation claim to the insurance carrier or the attorney. We demand a total refund unless the medical expenses exceed the available insurance. When this occurs, we then compromise our third party claim. This is done on an individual basis. It is not tied to a specific amount or percentage of coverage. Once the refund is made, the appropriate information is recorded on HCFA 64.9a. The same procedure is followed on

Exhibit 5

JAMES B. HUNT, JR.
GOVERNOR

SARAH T. MORROW, M.D., M.P.H.
SECRETARY
DEPT. HUMAN RESOURCES

STATE OF NORTH CAROLINA
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MEDICAL ASSISTANCE
INSURANCE BUILDING
336 FAYETTEVILLE STREET MALL
RALEIGH, NORTH CAROLINA 27601

Director
Barbara D. Matula

IN REPLY REFER TO CODE PITP

RE: Medicaid Recipient:
Medicaid File Number:
Date of Accident:
Your Insured:
Your Policy Number:

Gentlemen:

We have been advised that you are the insurance carrier for the above party who was involved in an accident with the above named participant in the North Carolina Medical Assistance Program. This Medicaid recipient may have received hospital and/or medical benefits through our program for treatment necessitated by the accident.

This is to inform you that the North Carolina Medical Assistance Program is a "last pay" program. The State of North Carolina, through Medicaid, has an assignment of benefits for the total amount of any payments it has made or will make on behalf of injured persons on the claim of such persons against allegedly negligent individuals, corporations, or firms. The statutory basis of the State's assignment is found in General Statute 108-61.4 (1977).

As soon as we can ascertain the amount of our expenditures, if any, for this individual, we will immediately notify you. In the meantime, please acknowledge that you have received notice of the State's assignment and that you will protect the interest of the State in any settlement negotiations.

However, should you receive a medical bill from a provider of medical services for the above recipient, with the following statement either stamped or typed on the bill, "Medicaid Recipient Benefits Assigned to the State of North Carolina" it will be permissable to pay the provider directly. When payment is made to the provider a copy of the transmittal letter must be forwarded to the Division of Medical Assistance, Third Party Recovery. This will enable the State to secure the proper refund from the provider.

Your prompt attention to this matter will be appreciated.

Sincerely,

Exhibit 6

JAMES B. HUNT, JR.
GOVERNOR

SARAH T. MORROW, M.D., M.P.H.
SECRETARY
DEPT. HUMAN RESOURCES

STATE OF NORTH CAROLINA
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MEDICAL ASSISTANCE
INSURANCE BUILDING
336 FAYETTEVILLE STREET MALL
RALEIGH, NORTH CAROLINA 27601

Director
Barbara D. Matula

IN REPLY REFER TO CODE PITP.

Re: Medicaid Recipient:
Medicaid File Number:
Date of Accident:

Dear Sir:

We have been advised that you are representing the above-named person with regard to personal injuries he/she sustained in the above-mentioned accident. This individual is a recipient of the North Carolina Medical Assistance Program (Medicaid) and may have received hospital and/or medical benefits under Medicaid for treatment necessitated by the accident. The State of North Carolina has Assignment of Benefit for the total amount of any payments it has, or will make on behalf of your client against the negligent individuals, corporations, or firms involved. This is in pursuance of General Statute 108-61.4 (1977).

As soon as we can ascertain the amount of Medicaid payments for this individual we will immediately notify you. In the meantime, please acknowledge that you have received notice of the state's assignment and that you will protect the interest of the state in any settlement negotiations.

However, should you receive a medical bill from a provider of medical services for the above recipient, with the following statement either stamped or typed on the bill, "Medicaid Recipient Benefits Assigned to the State of North Carolina", it will be permissible to pay the provider direct. When payment is made to the provider a copy of the transmittal letter must be forwarded to the Division of Medical Assistance, Third Party Liability. This will enable the State to secure the proper refund from the provider.

Your attention to this matter will be appreciated. We would also appreciate you advising us of the name and address of the liable party's insurance carrier.

Sincerely,

health insurance claims when we make a post-payment recovery. I'll make this comment right here - I know a lot of States are now no-fault as far as auto is concerned, but in North Carolina, the attorneys that run the legislature down there have seen fit not to go the no-fault route. We still have the old tort liability situation, so we do have cases where the amount of medical expenses far exceed the limit of liability on these insurance policies, so we do make compromises occasionally.

Our first requirement in our TPL procedure, however, is to first file the claim with the health insurance carrier. We require the provider to do this. This is on claims that carry the yes/no indicator and are identified. There must be a denial from the company or an insurance payment shown prior to submitting the claim to Medicaid. Should the provider not receive either a payment or denial within sixty days from the last date of service, then he/she can bill Medicaid.

Our claims processing system automatically denies a claim if it is filed within sixty days without the necessary information showing on the claim form. If the provider bills Medicaid after the sixty day waiting period, and a payment is not shown or denial is not attached, the claim is paid and shown on the TPL suspect list. We then check the hard master eligibility file in the State office for the health insurance information. If it is not there, we request it from the local county's files. When we secure this information, it is then transmitted to the provider with a request that he/she file with the insurance carrier and either submit a refund on payment or denial, whichever the case may be.

Now, we have given the provider six reasons that he/she can list on the claim form to override the sixty day waiting period. When one of these reasons is shown on the claim, it is paid and then shown on our TPL suspect with a unique code. We then take a sample from each suspect list. These suspect lists, by the way, are generated on each check and our contractor makes a payment twice a month. As I said, we take a sample from each suspect list and do a check to see if the information is correct or the providers are using the override reason as they should be. We have made it clear to them that we would discontinue these overrides if we find they are abusing the procedure.

Another thing that we have done that has proved very beneficial is the requirement of having the providers stamp their bills when sending them to an insurance company or an attorney upon request. Effective February, 1979, all providers are stamping their bills "Medicaid Recipient Benefits Assigned." As a result of this program, we have received many calls from attorneys and insurance companies, where liability cases are involved, asking how much they are to refund the Medicaid program. This has been more successful in a short period of time than we had ever thought. The providers have been very cooperative in the procedure. The resource areas that we go after in our recovery efforts are, of course, Medicare A and B, hospital and medical insurance, auto accident policies (which are total liability and Med pay), liability policies, homeowners, product liability, landlords and tenants, worker's compensation, CHAMPUS, Railroad Retirement, and to a certain degree, some veteran benefits.

Another area that we are beginning to be successful in is assault cases. When we are aware of an assault case and the victim has filed charges against the assailant, we notify the county prosecutor of the Medicaid payment. The

judges are making restitution of these medical expenses a part of the sentence. We collect these, of course, on installments. All of these types of recoveries are usually paid into the county court clerk's offices and, in most cases, held until the total has been paid and then submitted in one check to cover the entire refund. When a person is confined to a State institution and is on work release, the State corrections department furnishes us a monthly check until the amount is paid in full.

Another resource that we have found to be a big potential is hospital records. We have gone into the larger hospitals in North Carolina and, with the help of their staff, have located all the accounts that were carrying a credit balance. We then determine if this patient was a Medicaid patient at the time. If so, we then determine where the credit came from. Was it a third party payment, or a payment made by the recipient on admittance? If it was payment by the recipient, we advise a payment to the individual. If it was an insurance payment, or a payment by someone other than the recipient, we arrange a refund to the Medicaid program. One of the investigators in our shop, working with the four largest hospitals and two largest clinics in North Carolina since July 1, 1978, had secured refunds, at the time that I was in St. Louis, of $750,000. Now he has crossed the one million dollar mark just following up these credit balances on these accounts. This process has been very effective and as personnel is available, we will go into other hospitals and do the same thing. The nice part about this is that all of the hospitals have volunteered their own staffs to find these accounts, research them, and give us the answers. Other than spot-checking and assisting when asked, our manpower has been very limited in these types of exercises. Some of these accounts go back as far as 1973.

As a result of this effort, we have secured from the period July 1, 1978 through May 30, 1979 (eleven months of our fiscal year), already an excess of $5 million. This does not include any Medicare A and B prepayment. That will approximate $8 to $10 million annually, and since St. Louis, I found out it is going to be a little more than that. North Carolina is probably going to run close to $20 million annually on Medicare A and B. That, in a nutshell, is what we are doing in North Carolina. If any of you have any questions, feel free to ask them now or any time during the workshop. Thank you.

MINNESOTA

THIRD PARTY BENEFIT RECOVERY

Beth Wahtera

Manager, Benefit Recovery Unit

Minnesota Department of Public Welfare

Today, I would first like to give you a rundown on how we got started in third party in Minnesota and then, very briefly, explain what we are presently doing in TPL.

Minnesota maintains a post-payment recovery operation. However, it is not strictly post-payment in that the provider is given an option.

Number one, the provider may first bill the health insurance carrier, and if a balance still exists after receipt of insurance payment, the bill may be submitted to Medical Assistance (MA) for payment consideration. Or two, he/she may bill MA directly and the benefit recovery unit will pursue reimbursement from the appropriate third party.

In Minnesota, TPL first became a serious issue at the State level in early 1974. With the implementation of MMIS, it was apparent that the State had to realize what was legally required in the area of TPL, and had to decide how we were going to ensure that those requirements were carried out. Prior to MMIS, each county was responsible for insuring the utilization of third party resources and each county had its own variation of doing so.

Minnesota did a study on the level and methods of TPL activity in a sampling of counties representing both urban and rural populations. It was found that some counties were monitoring TPL on a cost avoidance basis while others, in essence, had a post-payment recovery operation.

As a result of this study, it was apparent that TPL was not being fully pursued. There are several factors attributing to this underutilization of available resources. One factor was that, for the most part, counties had failed to identify a specific individual or organizational unit responsible for monitoring and ensuring TPL utilization. Secondly, counties failed to adequately identify third party resources that did exist through employment, an absent parent, etc. The counties failed to encourage recipients to obtain insurance when it could have been available through employment, etc.

One of the counties surveyed, however, had begun emphasizing, on their own, the third party efforts in early 1973. This county was able to increase their collections (which totalled all of $1,499 in 1972) to $11,685. This represents an almost tenfold increase in collections. While this is obviously not a high dollar amount in itself, the caseload in point was only 121. Through this, it was obvious that other resources existed, but effort was needed to insure maximum utilization.

In conjunction with the county TPL activity survey, data was also obtained from other States. In addition, onsite visits were made to California and Michigan. Subsequently, the department established a specific focus on TPL utilization. First, they realized the decision had to be made on how to insure maximum TPL utilization. Second, the benefit recovery unit was established at the State level. Third, a need for sufficient enabling legislation was defined. Fourth, the department realized it had to determine which TPL function the State agency was to assume and which should be continued but reinforced at the county level. And finally, it was apparent that extensive communication had to be established for the provider populations, HIAA, the Blues, the county agency, and other groups with which the TPL function would ultimately interface.

The department obtained legislation in 1975 which provided the following:

(1) The department was given the rights of assignment and subrogation. The assignment was made a condition of eligibility.

(2) The insurance carriers were prohibited from writing exclusionary clauses denying or reducing the benefits due to the insured individual's MA eligibility.

(3) The State had the right to file a lien up to one year from the date of last payment of related medical care against any and all causes of action.

(4) Providers were required to indicate, on any bills released to recipients or representatives thereof, that MA financial responsibility was contemplated.

In 1976, the right of assignment was amended to include auto insurance as well as health insurance.

It was decided that the State should assume recovery for all third party cases for which the providers did not collect. It was known at this time that many providers were not accurately pursuing and/or reporting third party resources. It was also evident that the provider had little incentive to bill the third party, especially in cases where the recipient was uncooperative. At the same time, there is an ever increasing use of the superbill, which requires each individual to bill his or her own insurance as opposed to the provider performing this function. Therefore, it seemed unwise to require the provider to maintain a double billing system solely for insured MA recipients when, in fact, the provider may not be doing this for the private sector.

Throughout the time that TPL was being studied, it also became apparent that the counties were not accurately utilizing the other health coverage indicators on the case information file. A "Y" indicator is used to reflect the existence of insurance and an "N" indicator is used to reflect no insurance. It is the county's responsibility to update the indicators accordingly at the time of intake, as well as when a change in status occurs.

One of the first steps the benefit recovery operation did was to validate the case information file. The validation of the file was a manual process whereby case listings were produced for each county. The county was asked to verify the information and submit the specific health policy information for each case reflecting the "Y" indicator. The health insurance information was collected via the Benefit Recovery Information Form. This form has since been revised to enable direct key entry onto tape.

The listings used in the case information file also reflected the insurance indicator on file at that time. It was at this time, through the validation process, that we finally realized how questionable the accuracy of the insurance indicators actually were. Unfortunately, at first we did not have the foresight to audit the information we received. At this point in time, it seems that we were primarily concerned with getting a response from the county. We were under the assumption that the county would naturally supply accurate and complete insurance information. Once we had accumulated a

substantial amount of these forms and created more or less our own paper jungle, we realized that we did have to go back and stress our objectives. The data was in no way restricted to health insurance coverage.

To clarify our objectives, we conducted extensive county training seminars for instruction on completion of the Benefit Recovery Information Form and again for emphasis on why we requested and needed the information. These seminars greatly improved both the county's collection of the data and the contents of the information submitted to the benefit recovery unit.

Concurrent with the validation of the case information file, the Health Insurance Claim Form (Exhibit 1) was drafted and submitted to HIAA. We were also in the process of implementing TPL and injury codes (Exhibit 2) for use by the provider for which we consulted various provider organizations. While system enhancements were being completed for the post-payment identification and recovery, procedures were established in the interim for monitoring potential cases.

Each invoice was suspended if a potential third party payor existed and a staff of approximately four individuals manually reviewed these claims. If it was ascertained that a third party payor did exist, the provider was contacted and instructed to bill the third party. The specific insurance data necessary for billing was furnished and followup was performed to ensure that billing was done by the provider.

The unit was considered fully operational for post-payment recovery as of December, 1975. Resource areas presently pursued include health insurance, no-fault auto, tort liability, and worker's compensation.

The health insurance indicator is also reflected on the MA ID card. The provider indicates, through the use of the TPL code, whether or not he or she has billed the health carrier. The provider is also instructed to identify other potential resources such as no-fault or worker's compensation through the use of injury codes on the invoice. At point of adjudication, a Health Insurance Claim Form is produced for each invoice for which the provider has indicated he or she did not bill the health insurance carrier and the case information file reflects a "Y" indicator. The Health Insurance Claim Form contains all the data from the provider's original invoice but is reformatted for insurance submission. These claims forms are produced on a weekly basis at an average of over 1,600 per week. We presently maintain a dollar limit of $15.00 which reduces the paper volume by 50%, but is representative of less than 10% of the total dollar amount. Our average turnaround time from date of insurance submission to receipt of insurance payment or denial is 15-21 days.

Other liability is identified through three basic means:

1. Injury codes used by the provider

2. Diagnosis exception reporting

3. Matching of the worker's compensation pre-trial dockets against social security numbers.

Our dollar limit for identification of other liability is $100. By matching the worker's compensation pre-trial dockets with MA recipient

Exhibit 1

HEALTH INSURANCE CLAIM FORM - BENEFIT RECOVERY - DEPT. OF PUBLIC WELFARE

DPW-1848 (10-77)

PATIENTS NAME | DATE OF BIRTH | SEX

FILE NUMBER

PLEASE INCLUDE FILE NUMBER ON CORRESPONDENCE

PATIENTS MEDICAL ASSISTANCE NUMBER | RELATIONSHIP | ADMISSION DATE | DISCHARGE DATE

REFER TO ATTACHMENTS FOR FURTHER INFORMATION ON THE INSURED

ID # | REFERRING PHYSICIAN

INSURANCE INFORMATION

INQUIRIES ON CLAIM MAY BE DIRECTED TO:
Department of Public Welfare
Benefit Recovery Unit
Box 30199
St. Paul, Mn. 55175
Phone: 612 – 296 -

PRIMARY DIAGNOSIS

SECONDARY DIAGNOSIS

1 SERVICE DATE(S) | TO | PLACE | PROCEDURE | UNUSUAL SERVICE | UNITS/DAYS | DIAGNOSIS | CHARGE
PROCEDURE DESCRIPTION OR DRUG/SUPPLY NAME

2 SERVICE DATE(S) | TO | PLACE | PROCEDURE | UNUSUAL SERVICE | UNITS/DAYS | DIAGNOSIS | CHARGE
PROCEDURE DESCRIPTION OR DRUG/SUPPLY NAME

3 SERVICE DATE(S) | TO | PLACE | PROCEDURE | UNUSUAL SERVICE | UNITS/DAYS | DIAGNOSIS | CHARGE
PROCEDURE DESCRIPTION OR DRUG/SUPPLY NAME

4 SERVICE DATE(S) | TO | PLACE | PROCEDURE | UNUSUAL SERVICE | UNITS/DAYS | DIAGNOSIS | CHARGE
PROCEDURE DESCRIPTION OR DRUG/SUPPLY NAME

5 SERVICE DATE(S) | TO | PLACE | PROCEDURE | UNUSUAL SERVICE | UNITS/DAYS | DIAGNOSIS | CHARGE
PROCEDURE DESCRIPTION OR DRUG/SUPPLY NAME

6 SERVICE DATE(S) | TO | PLACE | PROCEDURE | UNUSUAL SERVICE | UNITS/DAYS | DIAGNOSIS | CHARGE
PROCEDURE DESCRIPTION OR DRUG/SUPPLY NAME

7 SERVICE DATE(S) | TO | PLACE | PROCEDURE | UNUSUAL SERVICE | UNITS/DAYS | DIAGNOSIS | CHARGE
PROCEDURE DESCRIPTION OR DRUG/SUPPLY NAME

8 SERVICE DATE(S) | TO | PLACE | PROCEDURE | UNUSUAL SERVICE | UNITS/DAYS | DIAGNOSIS | CHARGE
PROCEDURE DESCRIPTION OR DRUG/SUPPLY NAME

INSTRUCTIONS, CODE DESCRIPTIONS ON BACK

PAGE ☐ OF ☐ PAGES

TOTAL CHARGES | AMOUNT RECEIVED FROM OTHER SOURCES

T ☐ I ☐ MA ☐

CONTROL NUMBER | RESOURCES

AMOUNT PD. BY MA

PROVIDER

ID #

CERTIFICATION STATEMENT
THIS IS TO CERTIFY THAT THIS CLAIM CONSTITUTES A REQUEST FOR INSURANCE BENEFITS FOR SERVICES PROVIDED FOR AND PAID FOR ON BEHALF OF YOUR INSURED, UNDER THE TITLE XIX MEDICAL ASSISTANCE PROGRAM, DEPARTMENT OF PUBLIC WELFARE, STATE OF MINNESOTA. COLLECTION IS PURSUANT TO AUTHORITY ESTABLISHED BY MINNESOTA STATUTE CHAPTER 247.

X
SIGNATURE

SEND REMITTANCE TO:
Department of Public Welfare
Fourth Floor Centennial Building
ATTN: Cashier
St. Paul, MN 55155

Exhibit 2

THIRD PARTY LIABILITY (TPL) Codes

1. No insurance company indicated on Medical Assistance Identification Card.

2. One or more insurance companies billed.

3. Patients insurance company billed, but no amount was received as deductible amount had not been met.

4. Patients known insurance policies do not cover any part of claim.

5. Patients known insurance benefits applicable to this claim are exhausted.

6. Patients known insurance no longer in force.

7. Insurance company reject - reason unknown.

8. Provider unable to secure necessary papers and/or signature from recipient to allow claim filing.

9. No insurance company indicated on Medical Assistance Identification Card, but provider feels insurance coverage may exist.

INJURY Codes

The Injury Code most accurately describing the reason for treatment must be included on all claims submitted to Medical Assistance for payment.

1. *Problem not related to accident or employment.

2. Work-related accident or disease.

3. Accident.

4. Auto accident.

5. Auto accident occuring after 1-1-75 for which incurred expenses exceed $20,000 or contractual liability.

6. *Billing from Pathologists, Radiologists and Anesthesiologists. (New Code effective 9-1-75)

*Injury Code No. 1 and 6 are only necessary to assure that Injury Code field on the invoice is not blank.

numbers, we have found that an average of 26% of all worker's compensation cases involve Medicaid eligibles. In most cases, we have already identified the case through the injury or diagnosis code edits, but this serves as a backup means of identification. Upon identification of a potential resource, an accident injury inquiry is sent to each recipient (Exhibit 3). In cases of uncontested liability, the medical payment history and copies of the original invoices are submitted to the liable carrier for reimbursement.

As previously stated, Minnesota does have the statutory right to file a medical-surgical lien. Therefore, if liability is questionable or being contested, a lien will be filed. Minnesota's lien, as in some other States, is subject to attorney's fees. We have made it the general rule that the department will pay one fourth of the attorney's fees as opposed to the usual one third. If the case involves substantial work on the part of the attorney, we will allow one third. So far we have found that this procedure works very well.

This is the total report for all the reports that we receive on a weekly basis (Exhibit 4). The first two reports indicate "possible insurance coverage" and "insurance policy no longer in force." These two reports automatically generate worker messages to the county. If the provider has indicated that there is insurance and the case information file indicates there is no insurance, the county worker is requested to validate it.

The reports labeled "Accident: Possible Tort Liability," "Diagnosis," "Work Accidents," and "Auto Accidents" are all tort reports. This shows the amounts of claims that we identify in a week (the dollar amount for those claims identified and the dollar amount for claims below the constants that we are using).

In worker's compensation, we have had two very recent developments which benefit the department. Earlier this year in the Supreme Court, a case which dealt with the right of intervening parties to enter into the settlement negotiations in worker's compensation cases was heard. The opinion stated that the intervening party did in fact have the right to become a party to the settlement negotiations, thereby strengthening the department's stand involving reimbursement. It further stated that in cases where an intervenor is not involved in the negotiation process, its payments will be reimbursed at 100%.

Furthermore, a law was passed in this legislative session which states that in cases for which the department has paid medical expenses and for which these expenses are later determined to be compensable under worker's compensation, the department will be reimbursed in full with 12% interest. This law became effective August 1, 1979.

The benefit recovery staffing complement is presently 19, with approximately two to four temporary workers. In the last fiscal year, $9.1 million was collected in third party resources. This does not include Medicare. The benefit recovery budget for that year was $263,000 while the State budget was $459,785,000. Minnesota's MA recipient population is approximately 220,000 of which, at last count, 12.86% were health insured. Thus far, through April of this fiscal year, our recoveries have increased 12.7% over last year. We are presently in the process of totally mechanizing the

Exhibit 3

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE COMMISSIONER
612/296-2701

GENERAL INFORMATION
612/296-6117

Medical Service Date:

This form must be returned within 14 days.

We have received information which indicates you MAY have sustained an accident. (If you have not sustained an an accident, please read question number "1"). The following information is needed in order to process your medical bill, and to determine whether a third party might also be responsible for payment of the bill. Please answer all questions which apply to you. If a question is not applicable, please indicate "N.A." (i.e., "not applicable).

1) Is your injury the result of an accident? If yes, please give a brief description of how and where the accident happened. (IF YOUR INJURY IS DUE TO NATURAL CAUSES, AN ILLNESS, OR ANYTHING OTHER THAN AN ACCIDENT, PLEASE STATE SO HERE, AND IT WILL NOT BE NECESSARY TO COMPLETE THE REST OF THIS QUESTIONNAIRE.)

2) On what date did your accident occur?

3) What pharmaceutical drugs, if any, have you received?

4) Do you feel the accident was caused by or due to someone else? If so, who?

5) If your accident occurred at work, please answer the following:
   a) who is your employer and what is your employer's address and telephone number?

6) Please give the telephone number where you can be reached.

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PWBS376B OD-057 BENEFITS RECOVERY TOTAL REPORT 01/19/80 PAGE 1

REPORT #	REPORT NAME		CLAIMS	$ AMOUNT	CLAIMS BELOW CONSTANT	$ AMOUNT BELOW CONSTANT
1	POSSIBLE INSURANCE COVERAGE	OD-171	106	30,933.83		
2	INSURANCE POSSIBLY NO LONGER IN FORCE	OD-172	19	1,638.19		
3	ACCIDENT: POSSIBLE TORT LIABILITY	OD-173	145	57,980.35	867	33,690.00
4	ADJUSTMENTS REQUESTED TO INSURED CLAIMS	OD-175				
5	DIAGNOSIS INDICATES POSSIBLE TORT LIABILITY	OD-179	139	184,335.80	16	662.49
6	WORK ACCIDENTS	OD-1293	5	2,667.19	6	300.80
7	AUTO ACCIDENTS	OD-1292	21	17,292.81	53	2,580.51
8	OUTPATIENT CLAIMS WITHOUT COLLECTION	OD-1306	588	34,959.11	156	785.52
9	CHILD ABUSE CLAIMS	OD-1389	2	176.04	12	466.80
	HEALTH INSURANCE CLAIMS	OD-174	1,775	269,909.55	924	8,486.24

	# OF CLAIMS	# OF HICF PAGES
HICF TYPE A	1,664	1,669
HICF TYPE B		
HICF TYPE C	105	139
HICF TYPE D	6	6
HICF TOTALS	1,775	1,814

TOTALS

INPUT 4,868

PRINTED 2,800

TOTAL REPORT - END OF REPORT

health insurance billing. Presently, manual intervention is required. With the mechanized system, however, this will be reduced substantially.

At the back of the room I have some handouts that you may take if you wish. (See Exhibits 5,6,7 and 8 at end of text.) I hope that this has given you some idea of what we are doing in Minnesota.

Exhibit 5

HEALTH INSURANCE INFORMATION FORM

DPW 1922
(6-77)

1 Recipient Last Name 01 | First Name 02 | MI 03

Completion instructions can be found on the back of this form.

MA Identification Case Number 04 | Date of Birth 05

The information requested on this form is collected to determine whether you have any other health insurance which may provide medical payments in lieu of medical assistance. The collection of this information for program purposes is authorized by Chapter 247 of the 1975 Minnesota Session Laws. The information collected will be classified as private and will only be shared with county program staff, Department of Public Welfare Medical Assistance staff and specified insurance carriers. No other use of this information will be made without your prior written approval. You are under no legal compulsion to supply the information on this form, however, failure to supply all the requested information may make you ineligible to receive Medical Assistance.

2 Name of Insurance Company 06

Address of Insurance Claims Office 07 | City 08 | State 09 | ZIP Code 10

3 Check ALL Of The Coverage Types Which Apply Only To The Policy Indicated On This Form 11

- ☐ 1 Basic Hospital Insurance
- ☐ 2 Medical - Surgical Insurance
- ☐ 3 Major Medical Insurance
- ☐ 4 Dental Insurance
- ☐ 5 Vision Insurance
- ☐ 6 Nursing Home Policy
- ☐ 7 Indemnity Policy
- ☐ 8 CHAMPUS
- ☐ 9 Health Maintenance Orgonization (HMO) Insurance
- ☐ 0 Court Ordered Coverage / Absent Parent

4 A Is the indicated recipient also policyholder? 1 ☐ YES 2 ☐ NO 12
If 'YES', go to 4-B. If 'NO', complete the following:

Policyholder Last Name 13 | First Name 14 | MI 15

Address of Policyholder 16 | City 17 | State 18 | ZIP Code 19

4 B Type of Policy? 1 ☐ Individual 2 ☐ Group 20
If 'INDIVIDUAL', go to 4-C. If 'GROUP', complete the following:

Name Of Employer Or Group Under Which Coverage Is Maintained 21

Address of Employer/Group 22 | City 23 | State 24 | ZIP Code 25

Enter Group Number 26

Where are your claims submitted? 27
1 ☐ Insurance Company 2 ☐ Employer

4 C Contract Or Policy Number 28 | Ins. Start Date 29 | Ins. Term Date 30

5 Indicate ALL Individuals Covered Under Above Listed Policy And Relationship To Policyholder

First Name Of Covered Individual	CI #	Self	Spouse	Child	Step-Child	Other	(Specify)	
		☐	☐	☐	☐	☐		31
		☐	☐	☐	☐	☐		32
		☐	☐	☐	☐	☐		33
		☐	☐	☐	☐	☐		34
		☐	☐	☐	☐	☐		35
		☐	☐	☐	☐	☐		36

FOR COUNTY USE ONLY 38
Wkr. Name
Wkr. Number
Entry Date
1 ☐ Original
2 ☐ Update
3 ☐ Coverage Change
Service Cty.
Responsible Cty.

FOR STATE USE ONLY 39
1 ☐ Assignment
2 ☐ Subrogate
3 ☐ Suspend

Check If Continued 37 ☐

ASSIGNMENT OF BENEFITS FOR PRIVATE HEALTH CARE COVERAGE

I, the undersigned, wish to qualify for Medical Assistance for myself and/or my dependents from the Minnesota Department of Public Welfare under its Medical Assistance Program (the Program). I understand that, to the extent of such assistance provided, Minnesota Law gives the Department all of my rights to benefits under the terms of any private health care coverage which I have or may have. I also understand that the Commissioner of Public Welfare is empowered to accept from me an assignment of my rights under such private health care coverage.

Therefore, in consideration of any such assistance received by myself and/or any of my dependents listed below and including any unborn children, I, the undersigned, hereby assign and transfer to the Commissioner any and all rights to benefits accruing to me and/or such dependents during a period of one year, measured from the date below, under any private health care coverage which I have or may have, to the extent of the cost of care paid under the Program.

I hereby authorize payment to the Commissioner of any such benefits to which I may become entitled during such period of one year from any provider of such private health care benefits, to the extent of the cost of care paid under the Program.

I further authorize any person, physician, or other practitioner of the healing arts, hospital, clinic, or other medically-related facility, insurance company, employer, or other organization, business, or governmental agency to furnish upon request any and all records, data, and information regarding my health (including all treatment) and employment, and that of my spouse and children, to the Department and the provider of private health care benefits named below by the Department. A copy of this authorization shall be as valid as the original.

Medical and employment data obtained by the Department of Public Welfare for payment for any and all medical care shall be utilized only for the purpose of collecting your private health care benefits. Utilization of such data shall be effective November 1, 1975. This assignment shall terminate and become invalid upon termination of your Medical Assistance.

I further agree to indemnify and hold any person or entity making payment pursuant to this assignment harmless against all liabilities, cost, or expenses incurred as a result of such payment.

Date _____ Signature _____

Address _____

_____

DPW use only
Provider of health care benefits:

_____

_____
Medical Assistance ID number

Dependents:

_____
_____
_____
_____

DPW 1933
(3-76)

Exhibit 7

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

Attn: Claims Processor

During the 1975 legislative session, the Department of Public Welfare secured legislation, (Chapter 247), which mandates assignment of health insurance proceeds to which an insured recipient is entitled. Additionally, the legislation allows the Department the right of subrogation when the insured is not the recipient ... such as in cases where the absent parent is required to provide hospital/medical insurance on behalf of his/her dependent children.

The enactment of such legislation provides the statutory authority for the Department of Public Welfare, (Benefit Recovery Unit), to administer a Benefit Recovery Program, whereby the Department of Public Welfare bills the insurance company on behalf of the recipient, thus assuring reimbursement to the Department of Public Welfare. Additionally, this program will assure that the Department of Public Welfare is the "payor of last resort" ... subsequently reducing tax dollars expended.

BY VIRTUE OF THIS LETTER, THE DEPARTMENT OF PUBLIC WELFARE IS HEREBY EXERCISING ITS RIGHT OF SUBROGATION FOR BENEFITS DUE THE RECIPIENT NAMED ON THE ATTACHED BILLING STATEMENT. UNDER THE CONTRACT HELD BY YOUR INSURED _____, FOR SERVICES ENUMERATED ON THE ATTACHED STATEMENT.

Thank you for your assistance and cooperation. If you have any questions, or require additional information, please write or call the Benefit Recovery Unit.

Request of Payment Instructions

1. A check or draft covering benefits payable with an explanation of what is being paid. Checks should be made payable to the Department of Public Welfare.
2. Notices indicating no benefits payable because (a) No coverage for services rendered, or (b) Deductible not met, etc.
3. A notice that benefits have already been paid. This should include the name of the person(s) paid and the amount.
4. A notice that the recipient is not your insured.

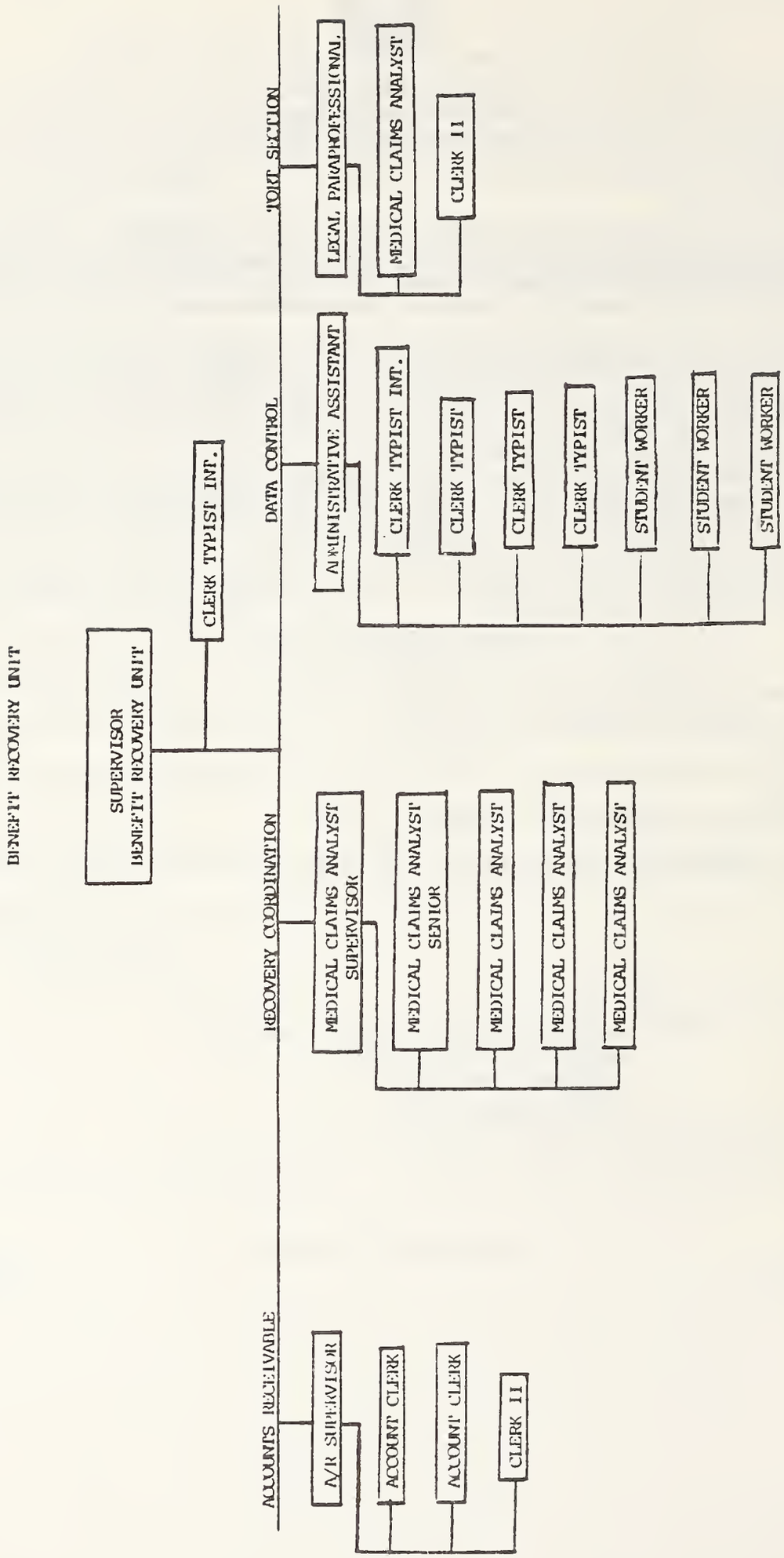
All drafts or disallowances must include the file number listed on the top right-hand corner of the billing form.

STATE DEPARTMENT OF PUBLIC WELFARE
BENEFIT RECOVERY UNIT
690 North Robert Street
P.O. Box 43170
St. Paul, Minnesota 55164

AN EQUAL OPPORTUNITY EMPLOYER

PZ-02323-01
DPW-2323 (9-78)

Exhibit 8


BENEFIT RECOVERY UNIT
SUPERVISOR
BENEFIT RECOVERY UNIT
CLERK TYPIST INT.
TORT SECTION
LEGAL PARAPROFESSIONAL
MEDICAL CLAIMS ANALYST
CLERK II
DATA CONTROL
ADMINISTRATIVE ASSISTANT
CLERK TYPIST INT.
CLERK TYPIST
CLERK TYPIST
CLERK TYPIST
STUDENT WORKER
STUDENT WORKER
STUDENT WORKER
RECOVERY COORDINATION
MEDICAL CLAIMS ANALYST
SUPERVISOR
MEDICAL CLAIMS ANALYST
SENIOR
MEDICAL CLAIMS ANALYST
MEDICAL CLAIMS ANALYST
MEDICAL CLAIMS ANALYST
ACCOUNTS RECEIVABLE
A/R SUPERVISOR
ACCOUNT CLERK
ACCOUNT CLERK
CLERK II

BLUE CROSS/BLUE SHIELD

Charles Tomek

Director, Plan Performance Division

Blue Cross/Blue Shield

All of you have a different perspective of Blue Cross and Blue Shield Plans, depending on your involvement. To augment your perspective, I am going to describe the Blue Cross and Blue Shield organization and some typical Plan practices. Later, I will speak about our third party liability operations and some key areas of interest between a Blue Cross and Blue Shield Plan and you.

Blue Cross and Blue Shield Plans

The Blue Cross and Blue Shield Plans did not invent health insurance. What Blue Cross and Blue Shield Plans have done is to take the idea of health care protection, refine it and develop it. Blue Cross and Blue Shield Plans have:

- Pioneered the idea of service benefits.
- Accepted all of the groups' members, including members' dependents, without trying to select good risks.
- Established unique relationships with physicians and hospitals to help influence the kind and quality of care subscribers receive.
- Developed ways of covering subscribers wherever they are.
- Entered the field of Health Maintenance Organizations to offer subscribers an alternative way of receiving care.

There are 69 Blue Cross Plans and 70 Blue Shield Plans in the United States today. In addition, there are six affiliated Blue Cross Plans -- five in Canada and one in Jamaica, and five affiliated Blue Shield Plans -- four in Canada and one in England.

Approximately two of every five Americans are members of a Blue Cross Plan. In 1977, membership in the Blue Cross Plans reached 83.5 million, or 38 percent of the population served by the Plans. Of this membership, 26 million persons were served by Blue Cross and Blue Shield Plans acting as intermediary in various capacities in Medicare, Medicaid and other public programs in the United States.

During the past 31 years, Blue Shield Plans have grown from nine Plans with a combined enrollment of 1.5 million members, to a locally administered and nationally coordinated organization of 70 Plans covering 70.9 million persons. In 1977, Blue Shield Plan enrollment represented 33.1 percent of the population serviced by the Plans.

In general, Blue Cross benefits cover hospital expenses, hospital outpatient care, many ambulatory (out-of-hospital) services, other institutional services and home care. Blue Shield benefits generally cover charges for medical, surgical, dental and other professional services.

The Blue Cross and Blue Shield Associations

As the number of locally developed Blue Cross Plans increased, a need for

national coordination became obvious; thus the Blue Cross Association was formed by the Plans in 1948.

By the end of World War II, the number of prepaid medical care plans had increased to the point that national coordination was both feasible and desirable. In 1946, nine Plans formed the Associated Medical Care Plans, forerunner of the Blue Shield Association.

The two Associations with their single staff have many responsibilities; briefly, they include:

- Serving as national spokesperson.
- Serving in a central coordinating role to help Plans with the many activities involved in handling national accounts. (Incidentally, this includes the largest voluntary employee group in the world -- the Federal Employees Health Benefit Program, under which more than 5 1/2 million government employees and their dependents, by their own choice, have Blue Cross and Blue Shield coverage.)
- Establishing and measuring standards of Plan performance.
- Operating a nationwide telecommunications network.
- Developing new benefits.
- Maintaining proposal services, Actuarial Departments and research services.
- Being prepared to help Plans find immediate solutions to problems.

Typical Blue Cross and Blue Shield Plan Practices

To meet the needs of all employers and future Blue Cross and Blue Shield Plan members, local Blue Cross and Blue Shield Plans developed a national delivery system that meets important national needs while capitalizing on the strengths of local Plan organization and accountability.

The responsibilities of a Blue Cross and Blue Shield Plan can be divided into two major areas: Customer Service and Claims Administration.

The Blue Cross and Blue Shield Plan identification card provides the central component of service. The ID card means access to the health care delivery system with a minimum of paper work or cash deposits because it is recognized by tens of thousands of physicians and thousands of hospitals across the nation. Inter-Plan coordinating mechanisms are maintained that make the ID card as acceptable away from home as it is at home. As a result, most health care facilities and providers will give service without requesting a cash deposit.

Although the ID card is important, it is not the only way Blue Cross and Blue Shield Plans provide service. Others include:

- When questions arise, or when something goes wrong, members have direct access to a local Plan's Customer Service staff to answer questions or solve problems.

- Members are provided benefit explanations that clearly identify the benefits to which they are entitled.

- Most health care providers and facilities file claims for covered members, which relieves the members of much of the task of collecting receipts and filling out forms.

Blue Cross and Blue Shield Plans administer claims by:

- Verifying the eligibility of the member or dependent.

- Verifying that the service is covered by the contract.

- Reviewing the claim for medical necessity.

- Reviewing the claim for appropriateness of charges against local fee profiles and negotiated reimbursement formulas.

- Paying the member's claims locally and, most of the time, paying the provider directly.

- Establishing and maintaining eligibility files.

- Establishing and maintaining programs to ensure sound relations between the Plan and local health care facilities and providers.

Coordination of Benefits

To protect Blue Cross and Blue Shield Plan members from the inflationary effects of overinsurance, Blue Cross and Blue Shield Plans include Coordination of Benefits provisions in their contracts. The purpose of Coordination of Benefits is to provide members all coverage to which they are entitled, but not more than the allowance for the services received.

Two methods of claims reimbursement are used in coordination of benefits processing: "pay and pursue" and "pursue and pay." Pay and pursue means that all claims are paid even if other coverage exists. Investigation for other coverage takes place after the claims are paid. The primary advantage is that claims are paid without interruption. The primary disadvantages are:

- Claims are paid that should not be paid; thus, these same monies must be collected later from other carriers, providers of health care or individual subscribers.

- It can be more difficult to obtain other coverage information from subscribers after claims have been paid.

Pursue and pay means that claims are paid if no other coverage is known to exist. In other words, payment of the claim is held while other coverage is investigated. The primary advantages are: only claims that should be paid are paid and a Plan has an excellent lever for obtaining other coverage information. The primary disadvantages are:

- Claims payments can be interrupted.
- A provider's cash flow is interrupted.

There are key functional groupings that encompass most of the third party liability processes. They are prevention, detection, investigation, evaluation and decision, collection, and reporting.

- Prevention covers account and provider education.
- Detection includes manual and automated screening of claims.
- Investigation includes querying the subscribers, providers and other carriers.
- Evaluation and decision are the actions taken on each claim.
- Collection is the collection of monies paid.
- Reporting covers the use of the information as a result of coordinating benefits.

Medicaid and the Blue Cross and Blue Shield Organization of Plans

For many years, Blue Cross and Blue Shield Plans have had a cooperative relationship with many State's Medicaid programs and, over the years, some State/Plan relationships have changed. Consequently, some Blue Cross and Blue Shield Plans have had experience with Medicaid needs, some Blue Cross and Blue Shield Plans now are fiscal agents, and some Plans have little operating knowledge about the Medicaid program. These general conditions require your understanding to effectively implement your third party liability programs.

The need for liaison and communication is anticipated. As individual State Medicaid third party liability units develop their third party liability programs, these units could first meet with local Blue Cross and Blue Shield Plans to develop areas of understanding and establish the needed administrative linkages.

Local Blue Cross and Blue Shield Plans will incur administrative costs in handling Medicaid requests, such as costs for eligibility determination, claims handling, et cetera. A couple of questions that could be important to you are:

- Can the initial costs a Plan will encounter be allocated back to the State?
- Can ongoing processing costs be allocated back to the State?

There is little uniformity throughout the many State Medicaid third party liability units, which makes it difficult for local Plans to develop a single method for handling Medicaid requests. A couple of questions might be:

- Can a uniform data set be developed?

- Can consistent forms be developed for use by all States?

Some considerations regarding the process of eligibility determination are:

- Who determines eligibility?

- Can a claim limit be used? (This would allow a Plan to concentrate on high payoff claims.)

- Is the use of automation feasible?

Information relating to claims is needed by Plans to facilitate prompt and successful State recovery efforts. The extent and type of information supplied by Medicaid in its requests for reimbursement must be sufficient to allow a Blue Cross and Blue Shield Plan to comply with the request. For example, a State should be able to:

- Identify the contract or membership number under which the recipient is insured.

- If possible, substantiate that coverage was in effect.

- Completely document the services provided.

Some other processing considerations are:

- Will an inquiry precede all payment requests sent to a Blue Cross and Blue Shield Plan and what is the expected volume?

- What is the expected timing for receipt of inquiry requests or claims? Blue Cross and Blue Shield Plans can respond better to inquiries within the most current 12 month period; older inquiries require more effort and cost to research, not to mention their actuarial effect.

Thank you, I will be here for the day to respond to your questions and interests.

(Blue Cross/Blue Shield's Other Party Liability glossary follows this text.)

OTHER PARTY LIABILITY

Blue Cross Association
840 North Lake Shore Drive
Chicago, Illinois 60611
312/440-6000

Blue Shield Association
211 East Chicago Avenue
Chicago, Illinois 60611
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The purpose of this Glossary is to present industry terms and definitions used by the Blue Cross and Blue Shield Plans and commercial insurers in their pursuit of nonduplication of health care coverage.

Although medicine is an integral part of the insurance industry, medical terms are not included in this Glossary as they can be found in various medical dictionaires.

Included in the Glossary are the different in-house terms used by Blue Cross and Blue Shield Plans and the commercial insurers which have identical meanings (e.g., agreement/contract/policy).

Unfamiliar terms used by the commercials in communication with the "Blue" Plans can be located in the Glossary.

- A -

ADJUSTMENT -- A claims transaction which changes the information concerning a paid claim.

ADJUDICATION -- (1) The determination of service eligibility according to a Patient's benefits.
(2) The process of defining specific values, based upon a Plan's interpretation of its legal agreements, for the responsibilities of the Plan, the Subscriber, the Provider, and of any other Carrier or Agency toward the payment of the original charge for a health care service.

ADMISSION -- Entry of a Member as an Inpatient to a hospital or other health care facility.

AGREEMENT -- A legal agreement between two or more parties (e.g., a Plan and a Group) for delivery of benefits.

ALLOWABLE EXPENSES -- The amount of the reasonable and customary medical expenses, at least a portion of which is covered under at least one of the multiple health insurance plans insuring the person for whom the claim is made.

ALLOWED AMOUNT -- Is the allowable adjudicated fee for a particular service before the application of coinsurance or deductible provisions.

APPLICATION CARD -- A document signed by the employee as notice of his desire to participate in the benefits of the Group plan. In a contributory case, this card also provides the employer with authorization to deduct contributions from an employee's pay.

- B -

BASIC BENEFITS -- A general term applied to scheduled hospital, surgical, or medical insurance coverages which usually pay the first dollar of such expenses.

BASIC CONTRACT -- Those benefits in a contract which are deemed necessary and desirable from all points of view as an initial package or starting point for building a total contract.

BENEFITS -- The amount payable by the insurance company to a Claimant, Assignee, or Beneficiary under such coverage.

BENEFIT ADJUDICATION -- (1) A process of determining whether a claimed service is covered under the Beneficiary's contract, what portion of the service is reimbursable, and what pricing rules must be applied to the reimbursable service.

(2) The process of defining specific values, based upon a Plan's interpretation of its legal agreements, for the responsibilities of the Plan, the Subscriber, the Provider, and of any other Carrier or Agency toward the payment of the original charge for a health care service if the benefit is an indemnity benefit and toward the payment of the Provider's allowed charge if the benefit is a service benefit and the health care service is a covered expense.

BENEFIT CREDIT -- The amount of money "saved" through application of a non-duplication provision on a specific claim accrued for a period, generally one year, as a credit against future claims.

BENEFIT PERIOD -- (1) The length of time that a Member is entitled to a specific contract benefit.

(2) A specific time interval during which a specified value(s) is to be applied toward the payment of a health care service(s). (Under major medical benefit plans, a benefit period is established when, within a designated period of time, covered expenses of a stated minimum amount are incurred.)

- C -

CANCELLATION -- The termination of a contract for delivery of benefits.

CARRIER -- A company which sells insurance coverage (e.g., commercial company, self-insured) or which markets prepaid health and medical coverages (e.g., Plan, independent health plan).

CLAIM -- A request for payment for services rendered to a Patient.

CLAIMANT -- Person or party making claim for the proceeds of a policy.

CLAIM DETERMINATION PERIOD -- That interval during which the limitations imposed by the Anti-Duplication Provision would apply. This is a variable item but normally consists of one calendar year.

CLAIM EXPENSES -- The expenses incurred in the settlement of claims, such as investigation and legal expenses and salaries.

CLAIM FORM -- A printed form furnished by an insurance company to assist a Claimant in establishing and substantiating proof of loss; the form may require statements from the Claimant, his Attending Physician(s), his employer, and, where appropriate, the Group policyholder.

CLAIM INCURRED -- A term used to include both paid claims and claims for which the extent of liability is known but for which no payment has yet been made. The term "payment" can apply, depending on company policy, to either drafts issued or drafts that have both been issued and cleared through banking channels.

CLAIM LOSS CONTROL -- A term applied to the efforts of the claim department to identify and give special attention to those unusual claims which, if paid indiscriminately, would result in benefits being paid in excess of those covered by the health insurance contract.

COINSURANCE -- A policy provision by which both the insured Member and a Carrier, in a specific ration, share the health care expenses resulting from an illness or injury (same as co-payment or co-pay).

COMMERCIAL INSURANCE COMPANY -- A company organized to provide insurance protection as a profit to the company.

COMPLEMENTARY BENEFITS -- A program of benefits designed to fill out or complete to a desired maximum the incomplete benefits offered by another program.

CONTRACT -- A legal agreement between two or more parties (e.g., a Plan and a Group) for delivery of benefits. Examples of a contract include Hospital, Physician, and Subscriber contracts.

CONTRACT NUMBER -- A numerical identification assigned to a contract.

CONTRACT RIDER -- A provision added to a Subscriber contract whereby the scope of coverage is increased or decreased.

CONTRACTING HOSPITAL -- A hospital which has contracted with one or more Plans to provide certain hospital services to members at an agreed rate which guarantees, if necessary, to provide such hospital service for a specified time regardless of the Plan's ability to pay.

CONTRACTING HOSPITAL AGREEMENT -- The legal agreement between the Plan and a hospital covering the provision of care for Plan members by a hospital and payment for such care by the Plan.

COORDINATION OF BENEFITS -- A provision optional to Groups whereby a Patient under duplicate Group coverage may recover the total amount of charges for any items of health services provided by either or both coverages but in no case an amount greater than the total medical expenses.

COVERAGE -- The extent of benefits provided under a Subscriber or Group contract issued by a Plan.

- D -

DEPENDENT -- A person other than a Subscriber included under a Subscriber contract.

DIAGNOSIS -- The statement of a medical condition, cause or disease, the cause of which may not be determined (e.g., admitting diagnosis, discharged diagnosis, etc.).

DIAGNOSIS CODE -- A numerical classification of terms descriptive of diseases, injuries, and causes of death; international morbidity code, manual of the International Statistical Classification of Diseases, injuries, and AMA Standard Nomenclature of Disease; Blue Shield Service and Procedure Code.

DIAGNOSTIC COVERAGE -- A benefit which provides for expenses incurred for diagnostic X-ray and laboratory examinations.

DOCTOR -- A doctor of medicine, a doctor of dentistry, or a doctor of podiatry or surgical chiropody who is duly and personally licensed to practice by the state in which he performs any service covered by the certificate and within the scope of his license and who, under such license, regularly charges and collects fees from Patients in his own right.

DUPLICATE COVERAGE INQUIRY -- A process between Carriers used in requesting coverage and payment information on Subscribers and/or their Dependents.

DUPLICATION OF BENEFITS -- Overlapping or identical coverage for the same insured under two or more health plans, usually as the result of contracts with different insurance companies, service organizations, or prepayment plans, also known as multiple coverage.

- E -

EFFECTIVE DATE -- The date on which the insurance under a policy begins.

ELIGIBILITY -- The condition of a person physically, morally, occupationally, and financially that makes him/her acceptable as an insurable risk.

ELIGIBILITY DATE -- The date on which an individual member of a specified Group becomes eligible to apply for insurance under a Group health insurance plan.

ELIGIBILITY PERIOD -- A specified length of time (e.g., 31 days) following the eligibility date, during which an individual member of a specified Group will remain eligible to apply, without evidence of insurability, for insurance under a Group health insurance plan.

ENROLLMENT -- In Group insurance, the process of explaining the proposed plan to eligible employees and assisting them to properly complete their application for coverage.

ENROLLMENT PERIOD -- Period during which employees are enrolled for a new Group case; period following an individual's eligibility date during which he may enroll for insurance without furnishing evidence of insurability.

EXCESS CARRIER -- When one plan has the Non-Duplication Provision and the other does not, the plan with the clause automatically assumes "secondary" responsibility in paying benefits.

EXCLUSIONS -- A provision in the certificate stating situations or conditions under which coverage is not afforded by the Subscriber contract.

- F -

FULL COVERAGE -- Any form of insurance which provides for payment without deduction, of covered expenses incurred in accordance with the terms of the contract.

- G -

GROUP -- A body of Subscribers enrolled through an employer, association, or other organization which has complied with the enrollment regulations applicable thereto.

- H -

HEALTH INSURANCE ASSOCIATION OF AMERICA -- A voluntary, nonprofit association of companies organized for the purpose of promoting "the development of voluntary health insurance providing sound protection against loss of income and other financial burdens resulting from sickness or accidental bodily injury."

HEALTH INSURANCE COUNCIL -- A council of eight national insurance associations which provides a central source of information and technical and practical counsel regarding health insurance coverage. It also provides liaison between insurance companies and hospitals, physicians, dentists, and other providers of health care.

HMO -- Health Maintenance Organization - any organization which provides comprehensive health care benefits to a defined population (enrolled membership) for a fixed fee per person per annum.

HOSPITAL -- An institution, legally constituted and licensed (if licensing is required), with organized facilities for diagnosis, treatment and medical supervision of sick or injured patients. It may have facilities for major surgery, rehabilitation or convalescent care or it may specialize in specific health areas, such as tuberculosis hospitals, psychiatric hospitals, etc.

HOSPITAL ADMISSION PLAN -- A procedure used to facilitate admission of persons covered by Group insurance to hospitals and to assure the prompt payment of insurance benefits to hospitals.

HOSPITAL BENEFITS -- An insurance benefit which provides payment for covered hospital expenses.

HOSPITAL CARE EXPENSE INSURANCE -- A comprehensive plan which provides broad insurance protection for illness or injury. These plans, which combine a Hospital-Surgical Expense policy with a Major Medical policy, cover practically all types of medical care expenses such as hospital fees, doctors' fees, necessary private duty nursing, and drugs. However, the insured must assume a portion of the Major Medical cost (known as the deductible amount) before Major Medical benefits will be paid.

- I -

INSURANCE COMMISSIONER -- A state official, usually appointed, who has the responsibility for the administration of the state insurance department and enforcement of the state insurance code or laws.

INSURANCE COMPANY -- A corporation or organization engaged in the business of insuring against loss.

INSURANCE DEPARTMENT -- A government department in each state, province, or territory charged with the supervision and licensing of insurance companies and agents and the general administration of insurance laws or codes.

INSURANCE EXAMINER -- The representative of a state, territorial, or provincial insurance department assigned to participate in the official examination of the affairs of an insurer.

INSURED -- A person whose life, health, or property is insured against loss.

INSURER -- A company or organization that insures others against loss.

INSURANCE POLICY -- A written legal document issued by an insurer setting forth the terms of the coverage and the rights and obligations of each party under the contract.

INTERNATIONAL MORBIDITY CODE -- A numerical classification of terms descriptive of diseases, injuries, and causes of death.

- M -

MAJOR MEDICAL -- Comprehensive coverage which extends from basic to major medical benefits with deductible and co-pay provisions which can be coordinated against.

-or- -- Supplemental coverage to pay or co-pay for hospital, medical, and other related expenses above a stated deductible and within maximum amounts and usually cannot be coordinated against.

MEMBER -- Any person included under the Subscriber's contract, including the Subscriber.

MEMBERSHIP -- (1) The state or status of being a Member.
(2) The collective body of Members.

- N -

NATIONAL ACCOUNT -- A Group or set of Groups whose Blue Cross and/or Blue Shield Members reside in more than one Plan area and who have signed an agreement with one or more Blue Cross or Blue Shield Plans to provide uniform benefits to their members.

NO-FAULT INSURANCE -- An insurance coverage protecting individuals against losses where the approximated cause is an automobile accident. This coverage is to restore the losses of the individual within the limit prescribed by appropriate law regardless of fault.

NON-DUPLICATION -- A term applied to controls within an insurance policy intending to limit or exclude benefits when the insured person has coverage under another plan of insurance including any of the service or prepayment plans.

NON-PARTICIPATING HOSPITAL -- A hospital which has not contracted with a Plan to provide hospital services to its Members.

NON-PARTICIPATING PHYSICIAN -- A Physician who has not entered into an agreement with a Blue Shield Plan to provide stipulated benefits and render service without further charge to the Subscriber.

- O -

ORDER OF BENEFIT DETERMINATION -- A procedure for determining which Plan has primary liability in providing payment first. The plan which pays additional benefits for "Allowable Expenses" not covered by the Primary Carrier - but not to exceed 100 per cent of total allowable expenses - is known as the "Secondary Carrier" plan.

OTHER CARRIER -- A company that provides insurance coverage (e.g., Plan, commercial independent health plan, or self-insured).

OTHER CARRIER LIABILITY -- A method to determine if a third party is responsible for any portion of the expenses incurred for health care services (e.g., Workman's Compensation, subrogation, coordination of benefits, etc.).

OVER-INSURANCE -- Persons insured under multiple insurance plans who collect an aggregate of insurance benefits that exceeds their allowable medical expenses.

- P -

PARTICIPANT -- The Subscriber and, under family certificates, the Subscriber spouse, and unmarried children as defined in the certificate of membership.

PARTICIPATING HOSPITAL -- A hospital which has contracted with a Plan to provide certain hospital services to Members at an agreed rate and which guarantees, if necessary, to provide such hospital service for a specified time regardless of a Plan's ability to pay.

PARTICIPATING PHYSICIAN -- A Physician who has entered into an agreement with a Plan to accept payment for services rendered to its Members in accordance with the Physician agreement.

PATIENT -- A person under treatment or care.

PAY AND PURSUE -- A method of other Carrier liability investigation in which the Provider/Subscriber is reimbursed before the case is investigated.

PHYSICIAN -- A person who is skilled in the art of healing and who is licensed by his/her state of residence to render medical or surgical treatment.

PLANS -- Separately incorporated, locally administered, not-for-profit corporations across the United States which are authorized to use the Blue Shield or Blue Cross name and emblems.

POLICY -- The legal document issued by the company to the policyholder which outlines the terms and conditions of the insurance; also called the policy contract or the contract.

POLICY ANNIVERSARY -- The annual renewal date.

POLICY EXCLUSION RIDER -- An agreement attached to and made part of the policy which excludes coverage for a named disease, disorder, injury, or physical impairment.

POLICY PERIOD -- The period during which a policy provides protection.

PRIMARY CARRIER -- The insurer who pays benefits first, regardless of other coverage.

PURSUE AND PAY -- A method of other Carrier liability investigation in which payment is withheld until the claim has been investigated and liabilities established.

PURSUE FOR "N" DAYS AND PAY -- A method of other Carrier liability investigation in which payment is withheld for specified number of days while the claim is investigated and liabilities established. If the investigation is not completed within "n" days, the claim is paid while the investigation continues.

- R -

RECOVERIES -- The process of recouping monies which have been overpaid to a Subscriber/Provider.

REINSTATEMENT -- The act of restoring a cancelled Member to an active membership with or without continuity of benefits.

RIDER -- A provision added to a Subscriber contract whereby the scope of its coverage is increased or restricted.

- S -

SAVINGS -- Monies which would have been paid to a Subscriber/Provider, had not investigation for duplicate coverage been applied prior to payment.

SECONDARY CARRIER -- A Carrier who will assume a share of the loss only after liability has been satisfied by another (primary) insurer.

SUBROGATION -- The Plan's right to recovery of money paid when it is found that another party is legally responsible for payment of expenses.

SUBSCRIBER -- The person to whom the Plan has issued a contract for benefits and whose name appears on the identification card issued.

SUBSCRIBER CONTRACT -- The documents which specify the legal obligations between the Plan and Subscribers.

SUPPLEMENTAL BENEFITS -- A rider or other form added to a Subscriber contract whereby the scope of benefits is increased.

SUPPLEMENTAL COVERAGE -- A rider added to a Subscriber contract whereby the scope of benefits is increased.

- T -

TERM -- A period of time for which an insurance policy is issued.

TERMINATION DATE -- (1) The date that a policy ceases to be in effect due to policy provisions.
(2) Usually refers to the date a policy is cancelled or the date on which an individual employee or dependent ceases to be insured.

TERM OF POLICY -- The period for which the policy runs. This is usually the period for which a premium has been paid in advance. In some instances, it may be for a year or longer even though the premium is paid on a semi-annual or other basis.

- U -

USUAL, CUSTOMARY AND REASONABLE (UCR) -- Usual - the fee usually charged for a given service by an individual Provider. Customary - a fee within the range of usual charges for most Providers of a given service with similar training, and experience within a given area. Reasonable - a fee which meets the customary and prevailing criteria; generally construed to mean the same as usual and customary.

- W -

WAITING PERIOD -- (1) The length of time between an employee's date of employment and his insurance eligibility date.
(2) The duration of time between the beginning of an insured person's disability and the start of the policy's benefits.
(3) The specified period of time following date of policy issue during which payment of benefits is restricted.

HEALTH INSURANCE ASSOCIATION
OF AMERICA

James F. Sullivan

Director, Group Claims Department

Aetna Life and Casualty

I want to thank Jim for mentioning this morning, early on, the changes to the extent that this is the last group that will convene under the existing nomenclature of the Medicaid Bureau. I might have had a little difficulty trying to explain to the HIAA an announcement of dissolution of the Medicaid Bureau following my presentation.

When I was invited to participate, and was delighted to accept, I had a number of concerns, one obviously the content of the remarks that should be made, and perhaps trying to walk the delicate line between under-communicating and over-communicating. Also, I had a recollection of an experience in Richmond, Virginia just about a year ago today. I was down here on a business meeting and had a chance to bring my wife with me. I took our local manager and a couple of his associates to dinner and found out that he was quite a student of the Civil War. As a matter of fact, an ardent collector of artifacts; quite serious about the whole thing. During dinner, he found out that my wife was quite involved in bicentennial activity for about two years in Massachusetts, and while obviously he had planned ahead of time, with some pomp and cermony, he presented her with two bullets, and said he could attest to the fact that they were both Civil War artifacts. He presented the first one to her, noting that while it had been fired, there were no marks of any kind, no blemishes, obviously it hadn't struck anything, and he said that through historical analysis, you could tell that that bullet had been fired by a Northern rifle. He then presented the second bullet with its obvious impact points, and he said, looking carefully at the marking, "and that bullet, you could tell, number one, that it was fired in a northerly direction, so it had to be from a Southern rifle, and secondly, ballistically you could tell that the object it struck was going in the same direction as the bullet." It's a pleasure to be back in Richmond.

Two associates with me today are David Pattison, Assistant Counsel, Washington Health Insurance Association of America, Staff, and Don Baird of the Prudential, and they will be assisting me as we proceed, particularly as we enter into a question/answer phase. While I think it necessary to go into some background information in terms of the industry's interest, involvement, and concern, if you will, as respects the reclamation process, I do want to get rather rapidly to the sole, and obvious reason for our being here, and that's compatibility with you.

In terms of background, the Health Insurance Association of America is an organization of 326 commercial carriers. They insure about a hundred million lives. The companies represent about 85% of the commercial insurance carriers in this country. Its interests and concerns are trying to insure consistency among the carriers, assist in terms of interpretation of regulation, serve as a funnel or platform to influence regulation/legislation, and involvement in anything that affects the industry, e.g., privacy most recently. They feel they have a very clear role, because of the divergency that may exist State-to-State. By that, I mean divergency among carriers. So basically, that's the HIAA. My individual company is the Aetna Life and Casualty of Hartford, Connecticut. There is one other industry organization that I think you should be aware of because you may have contact with them, and that's the International Claim Association. Here again, we are representing approximately 428 companies whose principal interest is one of fostering effectiveness, efficiency and fairness in claim administration.

Under the HIAA, and we talk primarily of the Council on Consumer and Professional Relations, we also have State Councils and many of you in

State TPL units would have already had a contact with reference to reclamation and our interest in it. Now if I might mention, just digressing for a moment, a reclamation manual produced by HIAA. I hope you have copies. They should have been sent directly to your individual State units. If you have not, I'd appreciate your getting in touch with one of the three of us sometime today, so that we may forward additional copies. I just don't think we are going to have the time to get into the degree of detail that is contained in this manual, and yet it will amplify just about everything that we touch on, so I'd encourage you if you don't have it available, or have not seen it. You do have State Council chairmen who are available to you, who are available to act as the liaison points with any commercial carrier operating within your respective States.

I'd like to get into a little bit of our reason for being. Back about four years ago or so, when we first began to see signs of reclamation processes in States like California, that was the first time that it hit home in terms of the major impact this could have on us. On our claim administrative procedures, on our expenses, and on our benefit payments, for that matter. To you it represents a very sizable income, to us a very sizable outlay of funds. But the funds are not really the important part. It's how to get at them, and how to get at them effectively. Retrospectively, we were of the opinion that if someone were qualified under a Medicaid program, and now I'm going back five or six years, they probably would not qualify, being insured if you will, under a commercial insurance contract. Obviously that was a false notion, and the falsehood became apparent when reclamation processes began. The intitial claims were really an onslaught; it was recognition by several States that the dollars were there to be claimed, and if you will, an unawareness in terms of our needs in regard to claim administration; and as a result, some conflict, even bordering on litigation. Becoming aware of this, and the obvious implications legally, the industry formed a task force through one of its committees.

On the individual side, at least from my perspective, is the way most of the volume will be generated. You might take on the individual side distinctions which is the fact that there are certain contract provisions that are more apt to come into play in individual underwriting or insuring. One thing that is unique about group insurance is that you don't individually undergo physical examination, nor are you individually concerned about things like pre-existing conditions. Generally, if you are at work on the date that an insurance contract is written, you are covered as are the spouse and the dependent children. Again, this is a group, you don't worry about the individual risk. Presumably, the group represents a cross section whereas an individual does not. The premium dollars are specifically arrived at on the basis of the risk assumed with the writing of the contract. So the application is a detailed, significant, personal background in terms of medical history. It sometimes depends upon the individual, and constraints within the policy, such as exclusions for pre-existing conditions. A silly analogy reflecting this might be: having a great deal of difficulty getting collision coverage from the insurance company on an automobile that was already destroyed. You are trying to monitor and evaluate the risk so that on the individual side, you'll find probably more of a delay in terms of turnaround time. But you reclaim the benefits. You may find some of the service coverage questions in terms of benefits available. That's probably the primary uniqueness to the individual. The majority of the benefit dollars will be on the group side.

Question: Some of the carriers pay what Medicaid was billed. Some carriers pay more than Medicaid has billed. The difference in paying for a service versus paying for a universal debt. Why do they want to pay us more than we bill?

Answer: First of all, a number of our contracts differ from your provisions of coverage due to the specifically stipulated things such as scheduled amounts. Others are tested by phrases such as customary, which are normally defined as prevailing fees. So that if we received a statement of services rendered, we might well arrive at a different benefit level than you would under the Medicaid program. We do have concerns on overpayments and they are discussed in the manual to the extent that you have expanded benefits within your program and we extend benefits without being totally aware of the specificity of yours, resulting in an overpayemnt which you may refund to the individual beneficiary, who is really not our policyholder. That excess benefit should not enure to the benefit of that individual.

We will pay different benefit dollars. As an example, consider Medicare Part B. If a physician takes an assignment, he must accept what the Part B carrier determines to be prevailing as full payment. You don't have that under a commercial contract. The fact that a physician takes an assignment has nothing to do with his right to bill at whatever his fee level is. However, we will determine benefits in accordance with our contract. Outside of scheduled amounts, you are generally talking about prevailing fees. The fee generally charged by the majority of physicians within that specialty within that geographic region or area -- very much like the Medicare definition, but without that enforcement on taking of an assignment. Also, under the adjustment period under Part B, you are more apt to adjust on a retrospective basis reflecting, for example, the inflationary effect on physician's fees. Our adjustment is more on a constant basis than yours is. There is not quite as long a reaction time to it.

Question: When we receive a hard copy of microfilm, microfiche used in the usual course of the business, is it acceptable to send the processing audit?

Answer: Not necessarily to satisfy the audit, but to satisfy the reclamation. In other words, if you were to submit to a carrier microfiche that identifies provider data, type of service, diagnosis, that's not the bill you received. It's not the claim form that you would receive. That's the documentation to look for in support of whatever you have generated through a system.

Question: What of the source document, the piece of paper that is filmed and destroyed?

Answer: I don't think there's any problem with that. You know where you've got a reproduction of it. I'm speaking more in terms of a composite microfiche or microfilm. This is like an explanation of benefits form that we might produce, which serves as a reflection of that backup documentation, but not as copy.

Question: Are you referring to a specific case of a claim by the intermediary of the State or the claim received by the State? Have your auditors gone in to review the process or the systems audit?

Answer: I'm talking about an audit, where you, on an individual State basis, send reclamations to 50 carriers, and those carriers reimburse you with funds under the other insurance contract. That's the file we would want to look at. The one on which we extended reimbursement benefits to you because of the payment that you made under Medicaid.

Comment: In effect what you're doing is acting as a reviewer of the claims of the State's own process, because the State is interested in the same direction as you are. So why would you do anything but assist them?

Answer: I think we are willing to extend help, if, for example, you came to us with a summary and said these are the expenses that were incurred for this individual; please reimburse us. We would reimburse you. Taking it a step further, we wouldn't pay a claim if you did not get some kind of claim for indication of a billing from a provider. In short, we're saying that we're coming along behind you, but we don't have those bills that you have. You want the money from us, but we don't have anything which verifies to us that those charges were actually incurred. One thing that "Time" eluded to is the fact that we're audited by the State insurance departments taking a look for the very same reasons to see whether we pay our claims properly, pay everything that the provider has charged, or whether we're attempting to hold back money and saying here's a bill for $50. We'll only pay $20 of that. The insurance departments' come in and take a look at that. The insurance departments' audits say, show me all of your documentation, show me all the claims that were submitted for this. They come in and pull out a file. If you made a payment, they want to see that documentation or that bill on which you've made that payment. They actually look for these bills. We may reach a stage where insurance departments come in and say, "Hey, I see you've reimbursed Medicaid for X number of dollars for an individual." You don't have any claim documentation on which you've made your payment. That's part of our problem.

There will be other times when we will have to come to you for hard copy. Situations like litigation that occurs subsequent to your payment and our payment of the claim, where we are caused to become involved in the defense of a case. There are a number of reasons why we have to come back to you. That is one of the reasons of my questions earlier, can you get at that documentation, that backup material. The other thing, for example, we could well have an allegation that we should have made a direct payment to a beneficiary. That you don't, in fact, have an assignment to hospital, that hospital submits a bill, we erroneously pay the patient and that money disappears, we will repay that hospital because we've agreed to recognize assignments.

Question: Are you presently accepting something less than what you might otherwise normally require on a direct claims submission from States and are you, therefore, letting States determine the benefit level for you?

Answer: A couple of years ago, reference was made to the fact that if we required from a State everything we required from an individual, then the State would have to provide the bill from that physician, that drug store receipt, that x-ray and lab, whatever it is. All we said, for example, is you may use such things as microfilm processes but you may not have the ability, practically, proficiently to give us the five bills that were sent in. However, if you can give me an explanation form that says we received charges from five providers for this kind of service, that is really all I need to pay a claim. I also need to be satisfied that you've got the backup, and that you are giving me the information extracted from that material.

Question: In terms of cooperation between States and insurance companies, you mentioned something which is not a problem right now, but it could be in the future. That is, clauses in contracts where the beneficiary and the policyholder are in separate homes. It is a general rule in the Medicaid program that the clauses can make it extremely difficult, especially in terms of absent fathers being requested to provide medical support, because he would then have to purchase an individual policy which would go beyond what Medicaid usually has available.

Comment: I would have to speak again on the individual carrier because we have been faced with so much of that in recent years in terms of the absent parent. If the parent responsible for the care, including medical care, of the dependent is called into court, identified for litigation of any sort whether it is a divorce proceeding or whatever, we'll in fact recognize that individual as a dependent even if a nonhousehold resident. As long as the responsibility is there so we can determine the primary responsibility.

Comment: In an absent parent situation with the dependent child not residing, in this case, with the father. The father has group health insurance. Will you provide coverage to that dependent child residing in another household where the situation with the court has so identified that parent as being responsible for that child?

Comment: Yes, and as a matter of fact, you often find duplicate coverage in these types of situations, where both the parent that has responsibility for the child as well as the other parent has coverage under a policy. It may be, for example, because the policyholder is providing free coverage for that worker and dependents, so you have situations where the dependent child is covered by two plans.

Comment: I think the only constraint we would have is to have assurance that that individual is legally obligated to provide that coverage.

Question: Do you have any programs or initiatives to detect the magnitude of duplicate payments, for example, payments from our program and your program for the providers or people getting payments for the providers or people getting payments for the same bills? One payment goes to the provider and one goes to the recipient.

Comment: We both rely to some extent on the provider. Since he/she initiates that, and could initiate that in both directions. We do some routine auditing periodically by sending out carbons of our drafts to both the

providers and the recipients of benefits and the insureds to assure that duplicate claims have not been submitted and paid. We've seen minimal duplication and it is fairly well policed in terms of your involvement and ours, because if you extend benefits and file with us on a reclamation basis, our response is going to be that we have paid in that situation and recovery effort would be made with regard to that provider.

Comment: Does HIAA have a position with regard to the potential for overpayment or the return of dollars to someone that is not in fact the insured? Does HIAA have any plans for overcoming or eliminating that exposure? We are concerned. Right now, along a regulatory or government agency perspective, we are being told that's what it says and that's where we send the money. We are standing here saying, but it's wrong and you shouldn't and you can't. I don't think that's been the result. I can't give an answer.

Comment: I might amplify that it's obviously a statutory problem. We have gone to the Congress and the reaction has been somewhat of a muted understanding, but nevertheless, they have in effect told us what's the difference. They are not too sympathetic to changing the law, which is obviously a difficult process. We had a task force meeting and decided that one of the most helpful ideas would be that if some of the States wrote letters to Congress or to members of the Ways and Means Committee or the Senate Finance Committee and gave us copies, then we could maybe enlarge our lobbying efforts by saying to them, "Look, this isn't just the insurance companies selfishly trying to get some money back. This is a legitimate problem for the State." I would say if you did that it would help us, because, frankly, we have failed to make any headway legislatively.

MEDICARE/MEDICAID CROSSOVER CLAIMS

Charles Smith

Methods and Procedures Analyst

Bureau of Program Operations

Health Care Financing Administration

I'm here because I am involved in two of the Medicaid/Medicare integration projects. It is in that capacity that I am here today, not as an official spokesman of the Medicaid Bureau. As you know, about two years ago when HCFA was organized, a team of people took a look at the Medicare/Medicaid process and tried to find some areas in which we could bring the administration of the two programs closer together. Out of this came 20 discrete integration projects. I have been on two of them. One was project 19 which dealt with the exchange of data between the States and Federal government. The other was project 20 which looked at the crossover claims process. We tried to take a look at the various processes involved to see how we could modify each side of the claims process and bring them closer together. We looked into the possibility of developing demonstrations of these revised procedures and what procedural, legislative, and policy changes would be needed to implement on a national basis. We looked at the claims process first with crossovers, and perhaps, some time in the future, other people will look at claims processing in total.

A crossover claim definition for our purposes, and a loose outline of my presentation will be found in the handout. (See end of text.) A crossover claim is one in which Medicaid and Medicare are jointly liable for some of the services provided to an individual who is entitled to benefits under both programs. The TPL problems of crossover claims basically lie in two areas: One is cost avoidance and the other is post-payment recovery.

First, the identification of crossover will be based upon an action that's taken either by the beneficiary or by the provider. It is up to the doctor when he or she submits the claim to Medicaid to show that Medicare is a third party. By the same token, when Medicare is billed, the doctor must show that there is Medicaid involvement for the service. As soon as you start relying upon doctors and/or beneficiaries, there is a chance of error. The failure of a State to identify Medicare as first payor on a claim can produce third party liability problems involving Medicare. The problems associated with this follow. First, you must identify it, and then you must come back to us for the money. We'll then tell you what data we need. You will give it to us, but we'll say it's insufficient. Then the negotiations go on and on. From a cost avoidance standpoint, if we can reduce the third party liability problem with proper identification of crossovers, we can then improve the data flow between the two programs and head in the right direction.

Secondly, when a provider realizes that someone is eligible for both Medicare and Medicaid, the provider usually bills Medicare, receives payment from Medicare, and copies it or sends it to Medicaid. This is bad for the doctor's cash flow; the doctor who provided services is required to file twice. For the last set of figures I had, less than 50% of Part B crossover claims automatically transferred from Medicare to Medicaid. The last problem involves duplicate program payments. The question was raised vis a vis the private sector where a provider bills both ways and gets duplicate payments. No one really knows the magnitude of the duplicate payment issue, because obviously, once a duplicate is caught it becomes a third party liability issue. In the minds of some suspicious bureaucrats, a shrewd doctor might figure out a way of billing both programs and get duplicate payment. The possibility does, at least, exist.

HCFA has several options. The first is not to do anything. Anyone who has read statements from the current Secretary of HEW realizes HCFA is not going to do anything. The next thing that we could do is encourage agreements similar to those that exist in a good many States, like Minnesota, in which Medicare, if a claim involves Medicaid, transfers the claim over to the Medicaid program. The next alternative is to expand the scope of agreements that presently exist. For instance under Part A, third party liability recovery for which a State would bill Medicare and get the check from Medicare just isn't done. Part B TPL claims may be billed directly to Medicare, but it must be done on a hard copy basis.

The last option is to look at the whole crossover claims process. Project 20 sought to improve claims processing on both sides of the payment interface, looking initially at the crossover claim, because that's something in which we both have a vested interest. Secondly, we hope to develop a system which would require the provider of service to submit one claim. This would maximize the exchange of both claim data and eligibility data between Medicaid and Medicare in a machine readable form. Anyone who has a fairly sophisticated data processing system knows that many of the costs of the claim process are at the front end of the system; it's the people cost and not the computer cost. To the extent that we could get both the eligibility and claims data going between Medicare and Medicaid in machine readable format, we felt that we could help reduce the administrative costs. Thirdly, we tried to assess the appropriate degree of consolidation or integration between the two claims processors. Lastly, what we wanted was a model that would be suitable for nationwide implementation. Something that works in only one State isn't going to be worth much if it is not universally applicable. For example, Medical Services of D.C. must deal with D.C. welfare, Virginia, and Maryland. So, if a system would only work for one of those three, there would be trouble. We hope to look at some of the technical, administrative, and legislative requirements that would be necessary to implement this data exchange on a nationwide scale.

We started to look at the identification problem. Whether you are a State or whether you are a Medicare contractor, how do you know you have a crossover? The State really has two prime sources. One is from the claim itself. The other is from their eligibility file. In other words, if you annotate your eligibility file with the fact of entitlement to Part A or Part B of Medicare, then a claim coming in showing no Medicare payment would be identified as a crossover, and you would have to either do post-payment recovery as a third party item or bounce the claim back.

Another source of data is the BENDEX file. Entitlement dates are now carried on BENDEX. I would suggest for those States that don't buy in for only medically needy, that you annotate those individuals to BENDEX to see if, in fact, there is Medicare involvement. For those States where you buy in for all Medicaid eligibles, you would routinely come back on the BENDEX. I propose, depending upon the degree of sophistication of your eligibility system, that you consider the annotation of this data to your recipient file. Presumably, if you have that Medicare eligibility annotated on your master file, then in the course of claims process itself, you can pick up some crossovers that should go to Medicare.

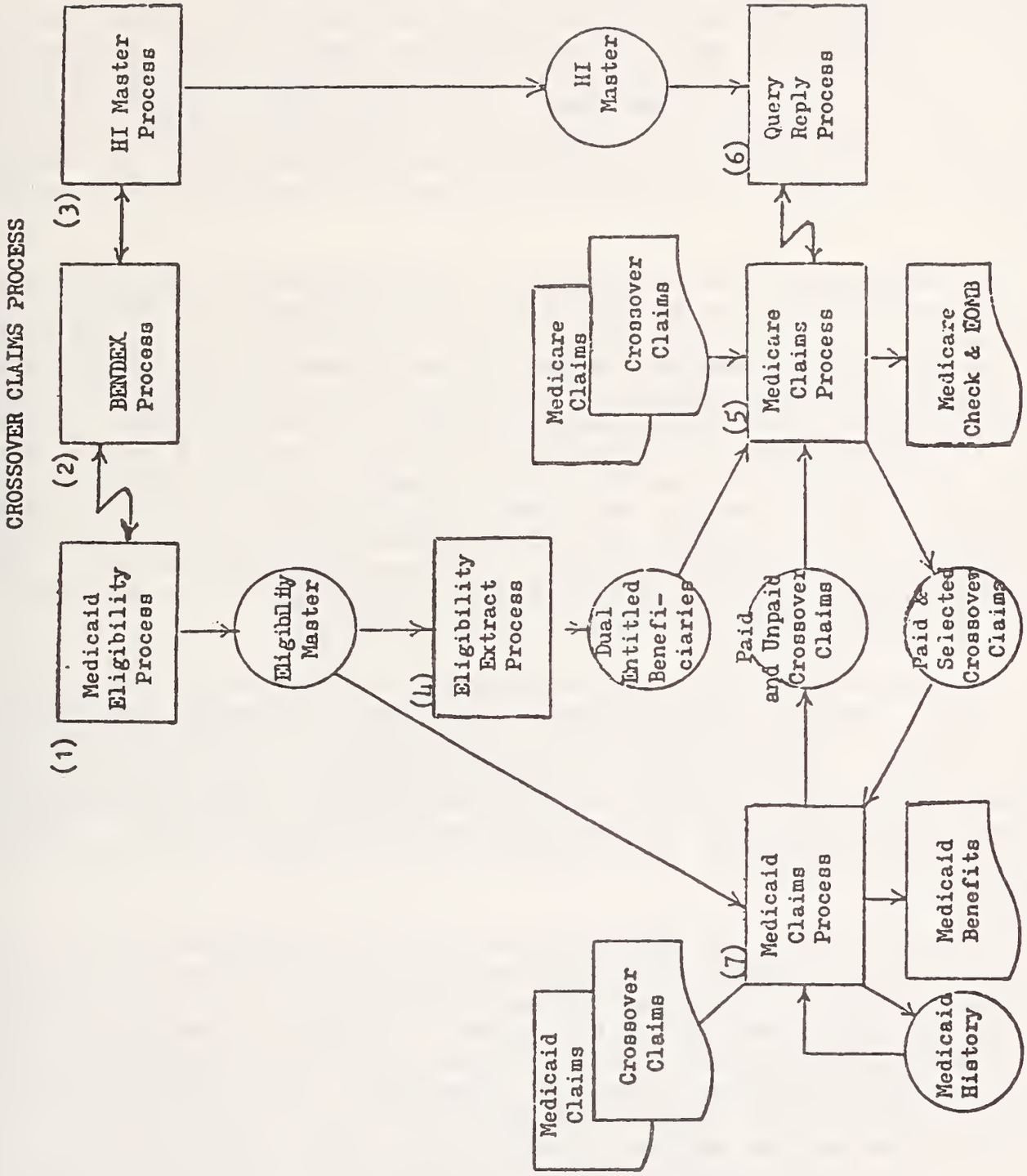
On the other hand, how would Medicare know that, in fact, it has a crossover claim which they could forward to the State agency? They would know from the Medicare claims form since the person involved has identified the claimant as a Medicaid recipient. Secondly, there is the possibility that some consideration must be given to the annotation of Medicaid eligibility to our health insurance master file, which every carrier and intermediary routinely questions as part of their claims process. The amount of data that would be carried, whether the Medicaid number, or periods of eligibility, are questions that are under consideration now. At least, thought is being given to carrying Medicaid data even if it is only a Medicaid flag on the HI master so that, as part of the query process, a carrier or intermediary could determine that this was the crossover claim and forward it.

Lastly, I said in St. Louis I hoped that there would be a series of Part B and Part A manual revisions after comments by the State agencies, addressing a Medicare/Medicaid standard data set. One of the provisions in these manual revisions is that the State be given the option to supply an eligibility file to a Medicare processor, and, whether the claim shows it or not, routinely extract crossover claims by matching the paid Medicare claims against the State supplied eligibility file.

What we have tried to do is develop a standardized data exchange. That is, a series of procedures utilizing nationally defined sets of data elements in specified electronic formats, allowing Medicaid and Medicare to identify crossover claims and, hopefully, to exchange the information more effectively.

Let us take a hypothetical situation. How would the claims flow and how would the eligibility data flow? (See Exhibit 1.) First of all, the State agency would identify its Medicaid eligibles to the BENDEX system. The BENDEX would show the entitlement data, the health insurance claim number, entitlement dates, and termination dates, if any. Any changes in the status of the people would come back automatically to the State agency. Simultaneously, that data could bounce against our master file and be lodged there. Periodically, perhaps once a week, the State agency would extract a file on those people who were duly entitled -- eligible for Medicaid and entitled to Medicare -- for Medicare contractors in their area. As part of the claims process, the carrier or intermediary would routinely match paid claims against this file. If a claim was received in which Medicaid involvement was found from any of these three sources, the claims would then be shipped to the State agency for Medicaid processing. The Medicaid/Medicare Explanation of Benefits would then be annotated telling the Medicaid/Medicare beneficiary that, in fact, the claim had been transferred for possible Medicaid payment. In addition to this, the State agency would have the option of forwarding both paid and unpaid crossover claims to Medicare on magnetic tape. In other words, if the State feels that Medicare would pay, they have the option of either bouncing the claim back to the provider and saying to bill Medicare, or forwarding that claim on tape to Medicare for payment. Payment would be made to the provider for the Medicare benefits. You would receive a copy of what Medicare did and you would then make your Medicaid determination based upon that. In the case of third party liability claims, you would identify them, collate a file in standard tape format, forward them either to the carrier or to the intermediary, who would take them through the routine Medicare process, and the check would be sent back to the State agency. Let me assure you, we won't pay you more than you have paid. The only stipulation on magnetic tape submissions would be if hard copies were

Exhibit 1


CROSSOVER CLAIMS PROCESS
(1)
Medicaid Eligibility Process
(2)
BENDEX Process
(3)
HI Master Process
Eligibility Master
(4)
Eligibility Extract Process
HI Master
(6)
Query Reply Process
Medicare Claims
Crossover Claims
(5)
Medicare Claims Process
Medicare Check & EOMB
Dual Entitled Benefi-ciaries
Paid and Unpaid Crossover Claims
Paid & Selected Crossover Claims
(7)
Medicaid Claims Process
Medicaid Claims
Crossover Claims
Medicaid Benefits
Medicaid History

required as part of the Medicare payment or adjudication process, we would have the right to call upon it, but it would be strictly on an exception basis. Routinely, if you would be giving us a magnetic tape, the data on that is fairly clean. I can visualize cases where justification of certain odd medical necessities, probably excessive charges, might need a call to the State agency asking, "Did you get a letter from the doctor saying this level of care was necessary?" Then, routinely (once a week), checks would be cut to the State agency for third party liability payments.

I'm almost afraid to mention this. First, there is obviously an audit stipulation which would be essential to the effort. Second, we don't want to encourage dumping. Please do not, on your first tape to your nearby Medicare carrier or intermediary, send them every Medicaid claim you have processed for the last year. This is something over which our carriers expressed concern. There will certainly be cases where the State agency feels Medicare is liable, but it turns out that it was outside a period of coverage. That's to be expected. The audits are specified in the draft regulations as being no more than once a year, unless the HCFA regional office deems it to be more frequent.

What would some of the impacts be? I would suggest that the State might obviously have to make use of this Medicare data coming in on BENDEX. They might want to use it in the course of case development. If you accept standardized data sets somewhere in your claims processing system, there would have to be a preprocess program to take standard Medicare format and convert it into whatever format your claims processing system would use. We have tried to address Medicaid required data elements. This is a sticky issue. There are some States that may have to seek some data elements from alternative sources. The two that always come to mind are "race" or "county of residence." The presumption is that your State Medicaid eligibility master file should have such things as "race" or "county residence" on them. It may be needed for the claims process, but I'm not sure that it really needs to come in on the input form or on the input tape data set.

You would have to enter into an agreement with the Medicare contractors in your area. What if a State wants to enter into an agreement with HCFA and says, "Okay, I will accept crossover claims from all carriers and intermediaries." There could be a single agreement with HCFA which would basically mean that if you're in a State that has half a dozen intermediaries and two or three carriers, you could get all of them at one time. That is seriously being considered. At this point in time, however, it's still on the drawing board.

On the other hand, the Medicare claims processing system would have to be modified to accept standardized data sets coming in from Medicaid, process them, and depending upon whether Medicaid made payment or not, either pay the provider and inform Medicaid of the payment, or pay the State agency in the case of third party recovery. Secondly, the carrier or intermediaries would have to accept the Medicare or Medicaid agreements. The entire initiative for exchanging data between Medicare and Medicaid is laid out at the feet of the States. It is not the carriers' option to say no. They might have to be flexible. In a case where a State's fiscal agent used to be a Medicare carrier and is now someone else, they don't always have the best of relations.

In pursuing these activities, we have tried to address the needs and concerns of all interested parties, the States, the Medicare contractors, the providers of service, and, most importantly, the recipients and beneficiaries.

CROSSOVER CLAIM PROCESSING

Medicare/Medicaid Integration Projects 19 and 20

I. Introduction

II. Crossover Claim Definition.

A claim on which Medicare and Medicaid are jointly liable for some or all of the services provided to an individual who is entitled to benefits under both programs by a provider who is eligible to receive payments from both programs.

III. Current Problems with Crossover Claims

IV. HCFA Options

V. General Goals of Crossover Claim Projects

VI. Strategy for Crossover Claim Identification

A. By Medicaid
B. By Medicare

VII. Strategy for Crossover Claim Process

A. Standardized Data Exchange

1. Definition

A series of procedures utilizing nationally defined sets of data elements in specified electronic formats that allow both Medicare and Medicaid to identify crossover claims, process them more effectively, and exchange eligibility data between programs.

2. Data Flow Under Standardized Exchange

3. Impacts to Medicaid

4. Impacts to Medicare

5. Benefits

B. Single Processor

C. Project Status

CIVILIAN HEALTH AND MEDICAL PROGRAM FOR THE UNIFORMED SERVICES (CHAMPUS)

Thomas Osoba

Chief, Program Policy Branch

Department of Defense

I'd like to share with you today a little about the history of our program. I think that might add some perspective as to who we are, the beneficiary population that we serve, our benefits structure, the early conflict between Medicaid and CHAMPUS, and the procedures on how Medicaid can get reimbursed for services rendered that CHAMPUS will cover.

First of all, let me begin with a definition of CHAMPUS. CHAMPUS is the Civilian Health and Medical Program for the Uniformed Services. It's a complex program, one of the most complex programs I've ever seen. We have a relatively small beneficiary population compared to Medicaid or Medicare. We have about 150 to 160 employees in Denver servicing a worldwide program.

On July 5, 1884, an appropriations act within the military stated that military physicians should attend the family of the officers and soldiers free of charge, whenever practical. It established health care benefits as a tradition versus a mandatory fringe benefit. Back in those days, the military was relatively small and very stable. Actually, up until the turn of the century, it wasn't very common for people to leave the States, or if they did, it was only to go to a few isolated areas. Very conceivably an enlisted person or officer could spend his entire career in one given location. His family and he could live on base or very close to a military facility. As time passes, history proves that we are a fairly warlike nation. We were constantly getting into wars and conflicts which expanded our military capabilities. Obviously, we needed more facilities to handle the increasing military population. Some of the conflicts that we got into as a nation, more specifically the Korean conflict, escalated our need for increased facilities for medical care. As a result of that, the Dependence Medical Act of 1956 was enacted, which provided very limited program benefits for retirees and dependents. It was only for inpatient care. It wasn't until the Military Medical Amendments of 1966 that CHAMPUS was established as we know it today. It has taken quite a few years to get the Department of Defense to care for the dependents and retirees of active military duty.

The following is the type of beneficiary population we serve. Dependents of active duty personnel of the uniformed services are the major group. Uniformed services consists of some of the obvious. The Army, Navy, Air Force, Marine Corps, Coast Guard and some of the maybe not so obvious, such as the commissioned corp of the U. S. Public Health Service and the National Oceanic and Atmospheric Administration, more commonly referred to as NOAA. Also, we cover retired members of the uniformed services, dependents of those retired members, dependents of the deceased active duty members or deceased retired members, spouses and children of active duty members of NATO, who in connection with official duties are stationed in the United States or passing through.

Unfortunately, the Veteran's Administration speaker isn't here today, so I will share with you a brief description of our CHAMPVA program. This program was created by Section 103B of Public Law 93-82 which is entitled the Veteran's Health Care Expansion Act of 1973 and became law September 1 of that year. Again, it basically covers the spouse or child of a veteran who has a total permanent disability resulting from a service connected disability, and also the surviving spouse or child of a veteran who died as a result of a service connected disability or at the time of his or her death had a permanent disability resulting from the service experience.

A couple of comments on our benefits. We have a full range of hospital services and supplies. We have services and supplies provided by skilled nursing facilities, special treatment facilities and RTC's. Residential treatment centers are usually for adolescents with psychiatric or behavioral problems. RTC benefits require preauthorization before they can be obtained. We also have services and supplies provided by physicians and other individual providers. Our range in benefits include: inpatient care, outpatient care, psychiatric, ambulance, and durable medical equipment, among others. Some of the special benefits which we offer are family planning, alcoholism, organ transplants, adjunctive dental care (in connection with a surgical procedure), and surgery. We have a program for the handicapped, which is available only to dependents of active duty personnel. The CHAMPUS program's benefits are available for different beneficiaries. You have, for example, different cost sharing when the beneficiary is on active duty, versus when he/she is a retiree. This adds to the complexity of the program, unfortunately.

The early conflict - Medicaid and CHAMPUS as last pay. Well, we both want to be last paid. The problem was recognized in 1974 when Michigan and California initiated inquiries into CHAMPUS regarding the primary payor issue. CHAMPUS had no authority to resolve this problem.

Here are some of the reasons why CHAMPUS thought they should be the last pay program. Keep in mind that the military health care plan centers around what is called the direct care system. This is the system that is run by the services at Walter Reed Hospital and Bethesda Naval Health Center. The Uniformed Service Medical Facilities proved the primary coverage and only when the military hospitals cannot handle the beneficiary population such as the retirees, or the dependents of active duty, only as a last resort are they allowed to go to the civilian hospitals. That's one reason we thought we should be last pay. The unique characteristic of having a career in the military is that you can retire at a relatively young age. It's not uncommon to see active duty personnel in their late thirties or early forties retiring after 20 years of duty. This allows them another career. With the additional career, many times you receive health care insurance through the new place of employment, again setting up the fact that CHAMPUS would be the secondary payor.

In legislative history, when the creation of CHAMPUS took place and Federal dollars were to be used, Congress wanted CHAMPUS to be the secondary payor. There were attempts by the Department of Defense and the Department of Health, Education, and Welfare to reach an agreement. In 1975, discussions on the problem were held in Washington between representatives of the legal counsel for HEW and DOD with no resolution.

Finally, in January 1977, policy issued by the Department of Defense stipulated CHAMPUS as primary payor to Medicaid. The official CHAMPUS regulation, DOD 6010.8-R, stipulated that CHAMPUS is primary. Chapter 8 of the CHAMPUS regulation specifically speaks to Medicaid and specifies in Section E of the regulation that between Medicaid and CHAMPUS, CHAMPUS will always be the primary payor.

The greatest potential problems are experienced when Medicaid payments are made in error. In those instances where Medicaid extends benefits on behalf of the Medicaid eligible person who is subsequently termed a CHAMPUS

beneficiary, CHAMPUS shall reimburse the appropriate Medicaid agency for such an amount as CHAMPUS would have paid in the absence of Medicaid benefits.

Reimbursement Requirements

The first condition under the reimbursement requirement is that the documentation required in order for CHAMPUS to make a reimbursement to a Medicaid agency, shall be established by the Director of CHAMPUS (or designee), and must provide sufficient information to permit the proper determination of the applicable CHAMPUS benefit. Before you have a reaction to the next requirement, wait until the discussion, because we do have an explanation for the time limit on reimbursement. It is the responsibility of the appropriate Medicaid agency to determine such other health and medical coverage under which a Medicaid eligible person can also seek reimbursement for medical services and supplies. So we put the onus on Medicaid. In order to receive reimbursement from the CHAMPUS program for Medicaid benefits paid in error, on behalf of a person subsequently determined to be a CHAMPUS beneficiary, the appropriate Medicaid agency must submit a request for the reimbursement no later than December 31 of the year following the year in which the medical service and/or supplies was provided. If you get a claim today, you have until December 31, 1980 to get that claim in.

The following discussion centers around the instructions we, OCHAMPUS, gave to our fiscal intermediaries. Here are the procedures established in what we call the CHAMPUS Interim Instruction which augments our contractual relationship with these FIs. On February 6, 1979, we sent the following instructions (see end of text). (As you can tell, it took about two years before DOD and HEW settled this issue.) CHAMPUS fiscal intermediaries have been provided basic procedures. The Bureau of Quality Control staff of HCFA are encouraging all Medicaid State agencies to emphasize the detection of other insurance or health program benefit program prior to payment of Medicaid claims. Realize, it's a lot easier said than done. When such claims are detected, the Medicaid State agency frequently will assist (these are instructions for FIs) in completing the claim submitted to the other program. Therefore, most claims forwarded by the Medicaid agencies will be claims that have not been reimbursed by the Medicaid agencies. Such claims will be processed by the CHAMPUS fiscal intermediary in the usual manner as though the beneficiary had submitted the claim directly, with reimbursement made directly to the beneficiary under current CHAMPUS instructions. We have nine fiscal intermediaries. Out of the nine, we have eight that are either a Blue Cross or a Blue Shield plan, the ninth is Mutual of Omaha. The largest is Blue Shield of California which processes about a million claims a year for us, and the smallest is Blue Cross of Tennessee.

The second way, of course, is after the fact, where possible CHAMPUS coverage is detected for a claim previously paid by the Medicaid State agency. The Medicaid State agency will prepare and forward a claim to the appropriate CHAMPUS fiscal intermediary which will process the claim in accordance with this instruction. Of course, it's more complicated if the claim has already been paid.

CHAMPUS was established as a primary payor over Medicaid in June 1, 1977, the date the new regulation was implemented. Therefore, the following

procedures will be utilized by CHAMPUS fiscal intermediaries and Medicaid State agencies in determining CHAMPUS reimbursement for beneficiaries who have received Medicaid payments for services and/or supplies rendered on and after June 1, 1977. The Medicaid State agency will contact the CHAMPUS fiscal intermediary to establish specific procedures for implementation of this instruction. Multi-State fiscal intermediaries are encouraged. Hopefully they are contacting you, but we need to know if they're not, to negotiate the uniform implementation procedures among the various State agencies with which they will be dealing.

The fiscal intermediary and the Medicaid State agency will document the agreed upon procedures and the contractor will forward to the Contractor Operations Branch at OCHAMPUS, a copy of the procedures and samples of the claims in payment documentation to be employed. The Medicaid State agency is responsible for obtaining from the beneficiary the CHAMPUS claim form with the top half properly completed with appropriate signatures. The reason this is so important is that CHAMPUS does not have a central enrollment/eligibility system. As such, we need the signatures, regardless what else we get or do not get on the claim form to process the claim. Without an enrollment/ eligibility system, which, by the way, we are working on, it's a matter of getting people, like the Department of the Army, Navy, Air Force, to sit down together to share common data with us. This to date has been most difficult.

The CHAMPUS fiscal intermediary will furnish a sufficient supply of CHAMPUS Form 500's (Exhibit 1) to State agencies. If you don't have them, contact the CHAMPUS fiscal intermediary who handles your State.

The requirement for authorization of services may be satisfied by an agreed on means. For example, Medicaid itemized claims are acceptable, claim service data printout, whatever is an acceptable means of identifying what took place - as long as the fiscal intermediary can process the claim.

The CHAMPUS claim form with attached service itemization, will be forwarded to the appropriate CHAMPUS fiscal intermediary. For each claim submitted, the Medicaid State agency will provide two copies of payment listings which contain as a minimum, the following information: The specific services paid by Medicaid, the amount of the payment for each service, and the individual to whom payment was made. The information contained in the State agency's payment record, retained for audit purposes, will usually satisfy this requirement. Each payment listing must be certified as accurate by a responsible State agency official. When high claims volume is encountered, the claims are to be forwarded by the State agency in batches of 50. The reason for that is, it is the common number in each batch that FIs process. If we can adhere to that, it would make the claims processing system that much more efficient. So send large volumes of claims in batches of 50, accompanied by the copies of the payment listing in each batch. The CHAMPUS fiscal intermediaries will process all State agency claims submitted in accordance with all applicable CHAMPUS requirements and definitions. In other words, they won't process a claim submitted by a Medicaid State agency any differently than if a CHAMPUS beneficiary sent in the claim.

These are the specific adjudication requirements. The fiscal intermediary shall verify the beneficiary's eligibility for CHAMPUS in the usual manner. The usual manner is to verify a signature and ID

Exhibit 1

CHAMPUS/CHAMPVA CLAIM FORM

For services or supplies provided by civilian sources except institutions

Read cover instructions and the back of this form before completing and signing!

Form Approved OMB No 022-R0382

Patient/Sponsor Information (Items 1 through 18 to be completed by the beneficiary/patient or sponsor)

1 PATIENT'S NAME (Last name First name Middle initial)

2 PATIENT'S DATE OF BIRTH MONTH DAY YEAR

7 SPONSOR'S NAME (Last name, First name Middle initial)

3 PATIENT'S ADDRESS (Street, city state, ZIP code)

PHONE NO (Include area code)

4 PATIENT'S SEX ☐ MALE ☐ FEMALE

8 SPONSOR'S SOCIAL SECURITY NO OR VA FILE NO

9 VA STATION NO

6 PATIENT'S RELATIONSHIP TO SPONSOR ☐ SELF ☐ SPOUSE ☐ NATURAL or ADOPTED CHILD ☐ STEPCHILD OTHER (Specify)

10 SPONSOR'S DUTY STATION OR ADDRESS FOR RETIREES

PHONE NO (Include area code)

5 MILITARY/VA IDENTIFICATION CARD

CARD NO

ISSUE DATE MONTH DAY YEAR | EFFECTIVE DATE MONTH DAY YEAR | EXPIRATION DATE MONTH DAY YEAR

15 IS CONDITION WORK RELATED? ☐ YES ☐ NO

MILITARY SERVICE RELATED? ☐ YES ☐ NO

AUTOMOBILE ACCIDENT RELATED? ☐ YES ☐ NO

11 SPONSOR'S BRANCH OF SERVICE ☐ USA ☐ USAF ☐ USMC ☐ USN ☐ USCG ☐ USPHS ☐ NOAA ☐ VA

12 SPONSOR'S GRADE/RANK

13 SPONSOR'S STATUS ☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED

14 DO YOU HAVE OTHER HEALTH INSURANCE? ☐ YES ☐ NO

IF YES, ENTER NAME OF OTHER PLAN OR PROGRAM

ADDRESS

CITY STATE ZIP

16 INPATIENT/OUTPATIENT CARE ☐ OUTPATIENT ☐ INPATIENT-EMERGENCY ☐ INPATIENT HOSPITAL-OUTSIDE 40 MILE RADIUS ☐ INPATIENT-SKILLED NURSING FACILITY ☐ INPATIENT-OTHER ☐ INPATIENT HOSPITAL-WITHIN 40 MILE RADIUS (ATTACH DD FORM 1251)

14a TYPE OF COVERAGE ☐ EMPLOYMENT (GROUP) ☐ MEDICAID ☐ STUDENT PLAN ☐ PRIVATE (NON-GROUP) ☐ MEDICARE ☐ OTHER

17 DESCRIBE CONDITION FOR WHICH YOU RECEIVED TREATMENT IF AN INJURY NOTE HOW IT HAPPENED

14b OTHER IDENTIFICATION NUMBER

14c EFFECTIVE DATE MONTH DAY YEAR

14d OTHER PROGRAM THROUGH EMPLOYMENT? EMPLOYER NAME

18 SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CLAIM INFORMATION AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION READ INSTRUCTIONS AND BACK OF THIS FORM BEFORE SIGNING

SIGNED DATE RELATIONSHIP TO PATIENT

Physician/Other Provider (Items 19 through 33 are to be completed by the physician or other provider.)

19 NAME ADDRESS & PHONE NO OF REFERRING PHYSICIAN

20 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (other than home or office)

☐ PRIVATE PRACTICE or ☐ UNIFORMED SERVICES

21 PROVIDER OF SERVICES ☐ ATTENDING PHYSICIAN ☐ OTHER

22 HOSPITALIZATION INFORMATION ADMITTED MO DAY YEAR DISCHARGED MO DAY YEAR

23 LAB WORK OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES

24 DIAGNOSIS SYMPTOM OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 or DX CODE

1.
2
3

25 A DATES OF SERVICE MO DAY YEAR	B PLACE OF SERVICE	C PROCEDURE CODE IDENTIFY	D DESCRIBE PROCEDURES SUPPLIES FOR EACH DATE SUBMIT REPORT EXPLAINING UNUSUAL SERVICES OR CIRCUMSTANCES	E DIAGNOSIS CODE	F CHARGES	LEAVE BLANK

26 PATIENT'S ACCOUNT NO

27 PROVIDER'S SOCIAL SECURITY NO

28 PROVIDER'S EMPLOYER ID NO

29 PHYSICIAN'S OR OTHER PROVIDER'S NAME ADDRESS ZIP CODE & PHONE NO INCLUDING AREA CODE

PROVIDER NO

G TOTAL CHARGES $

X AMOUNT PAID BY BENEFICIARY $

AMOUNT PAID BY OTHER INSURANCE $

32 AGREEMENT TO PARTICIPATE (READ BACK OF THIS FORM) ☐ YES ☐ NO

33 SIGNATURE OF PHYSICIAN OR OTHER PROVIDER READ BACK OF THIS FORM BEFORE SIGNING

SIGNED DATE

*PLACE OF SERVICE CODES
1 — HI — INPATIENT HOSPITAL
2 — OP — OUTPATIENT HOSPITAL
3 — DO — DOCTOR'S OFFICE
4 — IH — PATIENT'S HOME
5 — DCF — DAY CARE FACILITY (PSY)
6 — NCF — NIGHT CARE FACILITY (PSY)
7 — NH — NURSING HOME
8 — SNF — SKILLED NURSING FACILITY
9 — AMB — AMBULANCE
0 — OL — OTHER LOCATIONS
A — IND — INDEPENDENT LABORATORY
B — OF — OTHER MEDICAL SURGICAL FACILITY
C — (PSY) — RESIDENTIAL TREATMENT FACILITY
D — (STF) — SPECIALIZED TREATMENT FACILITY

CHAMPUS FORM 500 JUNE 1976

number. The ID number is fairly easy to get. Only those CHAMPUS covered services and supplies paid by the State agency will be considered for payment. Claims requiring additional development will be returned to or go through the Medicaid State agency. So hopefully, you and our FIs are talking to one another.

Timely filing requirements will be observed. Claims requiring additional development will be returned to or developed through the Medicaid State agency.

Duplicate charge screens will apply. Where a charge was previously processed for payment or denial by the CHAMPUS fiscal intermediary, the Medicaid State agency will be so notified by CEOB, which is CHAMPUS Explanation of Benefit. CHAMPUS reimbursement will be made solely to the Medicaid State agency. Where a claim is subsequently submitted for services reimbursed to the State agency, payment will be denied as a duplicate charge whether the subsequent claim is submitted by the beneficiary or by the participating provider. In other words, if the Medicaid State agency sends us a claim, and we pay it, we certainly are not going to pay the beneficiary or provider if he or she submits the same claim. We'll tell the beneficiary or provider that the money went to the State agency.

Using the amount billed to Medicaid as the billed charge, the fiscal intermediary will calculate the amount which would have been payable by CHAMPUS in the absence of other coverage, that is, the CHAMPUS determined reasonable charge less the cost share and any deductible. Our reasonable charge determination center on three factors. We use the bill charge, the customary charge, and/or prevailing charge - we take the lower of the three, pay that amount. Usually, the lower of the three is the prevailing charge. Recently we moved to what is known as the 80th percentile. Those familiar with reasonable charge determinations know that if you apply a prevailing charge of 4 out of 5 physician charges, which is 80th percentile, versus our old profile which was 3 out of 4, or at the 75th percentile, you're not talking about a lot of difference, if any. It's going to cost more money to implement that 80th percentile than benefit dollars will be realized. There will be instances for a Medicaid denied charge that is subsequently submitted to CHAMPUS by the beneficiary or provider for processing. Since the charge was denied by Medicaid, CHAMPUS reimbursement to the State agency will not have been made, and the charge may be processed by the fiscal intermediary in the usual fashion. In some cases there are benefits we pay that Medicaid does not. The amount of the CHAMPUS reimbursement to the Medicaid State agency is limited to the lower of (a) the amount of the payment made by the Medicaid State agency, or (b) the CHAMPUS determined reasonable charge less normal deductible and cost share.

In most cases, the Medicaid approved charge is less than the CHAMPUS determined reasonable charge. Providers often bill Medicaid for the amount which Medicaid allows. Providers may not then resubmit the claim to CHAMPUS for an adjustment to the higher potential CHAMPUS determined reasonable charge. Such claims are to be denied as duplicates. If the bill charge can be taken at its face value, which we're going to have to do, otherwise, you have an administrative nightmare - you have to use that amount.

The Medicaid State agency, in order to be eligible for payment, must agree to accept the lower of the Medicaid payment or OCHAMPUS determined

reasonable charge less any deductibles and cost share, as full payment for services rendered to CHAMPUS beneficiaries. I don't know if you're familiar with the different types of cost shares that we have. For example, if you're a dependent of active duty personnel, your cost share is 20%, you have a $50 deductible per year, or $100 per family. If you're an inpatient in a hospital, you pay approximately $4.75 a day or $25, whichever is greater. Now if you're a retiree, and a dependent of a retiree, your cost share is 25%, an additional 5%, you have the same deductible. But your inpatient care is 25%.

The CHAMPUS fiscal intermediaries are accountable for effective control of all claims submitted by the Medicaid State agency and for reporting to the State agency the CHAMPUS determinations made on each claim. Where possible, fiscal intermediaries will issue a summary check to the State agency for all claims processed during the payment cycle versus a check for each claim submitted. An individual or summary CHAMPUS explanation of benefits will accompany each CHAMPUS payment to the State agency. A CEOB will not be mailed to the beneficiary or provider. For each service originally paid by the State agency, the CEOB must indicate CHAMPUS payment or denial (and denial reason). The fiscal intermediaries assure that CEOBs provide sufficient information to enable the State agency to correlate each CHAMPUS processed claim with the State agency's own payment listing. Basically what we're getting at here, is that the FIs are responsible to account to OCHAMPUS. Our FIs are responsible to account dollars to OCHAMPUS that they paid out and to whom they paid them, including Medicaid. So the CHAMPUS fiscal intermediaries in this instruction, will submit all payment records for claims paid to Medicaid State agencies with a "one" code record in position 78 in the appropriate record. This is our payment tape, and this is how we reimburse and exchange funds.

The Medicaid State agency or HEW Quality Assurance staff submit some CHAMPUS claims as results of quality assurance reviews designed to detect the presence of eligibility for other health benefits programs. In such instances, the agency will submit the claim in the same manner as described previously. The CHAMPUS fiscal intermediary will determine eligibility for CHAMPUS payment and reimburse the State agency, notifying the submitting office of the action taken in the manner as earlier described in step 8. CHAMPUS fiscal intermediaries should direct any questions concerning these instructions in procedures to the Contract Operations Branch at OCHAMPUS. The fiscal intermediary must notify the Contract Operations Branch and obtain advance approval for any deviations from these instructions.

The Effective Date of Implementation

These instructions are effective on a date to be mutually established by the CHAMPUS fiscal intermediary and the Medicaid State agency. Hopefully, that's already been done. No claims are eligible for payment of services performed prior to June 1, 1977. Under transitional authority, in OCHAMPUS, the timely filing requirement as specified in Chapter 7d, claims filing deadlines shall not apply to Medicaid claims covered by these instructions for services performed from June 1, 1977 through December 31, 1978. CHAMPUS has notified HEW about these procedures and instructions, and HEW will notify the State agencies. The State agencies will contact the CHAMPUS fiscal intermediary to establish implementation. The CHAMPUS fiscal intermediary will notify

OCHAMPUS if the date of implementation proposed by the fiscal intermediary is not acceptable to the State agency. The CHAMPUS fiscal intermediary will also notify the contract operations branch in writing of the agreed upon date of implementation.

Some unique CHAMPUS characteristics we can share with you today are that we have a very complex claim form, intentionally designed because of lack of an enrollment/eligibility system. Virtually nothing happens at CHAMPUS until a claim form is submitted. So everything relies upon a claim form. We have a complex benefit coverage package, and because there is no enrollment/eligibility system, we rely very heavily on that claim form. We can help if you are experiencing reimbursement difficulties with our FIs. Certainly let us know in writing, so we have documented evidence when we go back to identify if you are running into problems. Use as the OCHAMPUS contact, the Program's Operations Branch.

(A list of CHAMPUS intermediaries and CHAMPUS Interim Instruction 7-79 follow this text.)

CHAMPUS INTERMEDIARIES

Hawaii Medical Service Association
1504 Kapiolani Boulevard
P.O. Box 860
Honolulu, Hawaii 96808

Blue Cross of Southwestern Virginia
P.O. Box 13047
3959 Electric Road, S.W.
Roanoke, Virginia 24045

Blue Cross of Tennessee
Blue Cross Building
Chattanooga, Tennessee 37402

Blue Shield Plan of Pennsylvania
P.O. Box 65
Camp Hill, Pennsylvania 17011

Blue Cross of California
4121 Camino Delrio, South
San Diego, California 92108

Mutual of Omaha Insurance Company
P.O. Box 456
Downtown Station
Omaha, Nebraska 68101

Blue Cross of Washington and Alaska
15700 Dayton Avenue, North
P.O. Box 327
Seattle, Washington 98111

Wisconsin Physicians' Service Insurance Corporation
P.O. Box 1787
Madison, Wisconsin 53701

Blue Cross of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

DEPARTMENT OF DEFENSE

OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

DENVER, COLORADO 80240

Date of Issue: February 6, 1979

CHAMPUS INTERIM INSTRUCTION 07-79

SUBJECT: MEDICAID: Primary Payor/Double Coverage Procedures

Reference: DOD Regulation 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," Chapter VIII, Section E, Title XIX of the Social Security Act, as Amended: Medicaid

Purpose: This CHAMPUS Interim Instruction sets forth the procedures which fiscal intermediaries shall follow in reimbursing Medicaid State Agencies for payments made on behalf of CHAMPUS beneficiaries for whom CHAMPUS has primary payor responsibility.

Background: The legislative acts establishing Medicaid and CHAMPUS established each program as a secondary payor to all other forms of health coverage. With the development of the CHAMPUS Regulation (DOD 6010.8-R), the Department of Defense determined that it was not the intent of CHAMPUS to require any beneficiary to resort to a welfare program or to submit to a means test before payment of CHAMPUS benefits. Beginning with the implementation of the new Regulation, Medicaid was determined NOT to be a double coverage plan. CHAMPUS became the primary payor where Medicaid eligibility was present for a CHAMPUS beneficiary.

Chapter VIII of the CHAMPUS Regulation speaks to Medicaid and specifies, in Section E, as follows:

"1. Medicaid: CHAMPUS Always Primary Payor. Whenever a CHAMPUS beneficiary is also eligible for Medicaid, CHAMPUS is in every instance the primary payor. This applies to all classes of CHAMPUS beneficiaries, i.e., dependents of active duty members, retirees, dependents of retirees, dependents of deceased active duty members and dependents of deceased retirees.

"2. Medicaid Payments Made in Error. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined

will assist the individual in completing the claim to be submitted to the other program. Therefore, most claims forwarded by the Medicaid agencies will be claims that have not been reimbursed by the Medicaid agencies. Such claims will be processed by the CHAMPUS fiscal intermediary in the usual manner, as though the beneficiary had submitted the claim directly, with reimbursement made directly to the beneficiary under current CHAMPUS instructions.

Where possible CHAMPUS coverage is detected for a claim previously paid by the Medicaid state agency, the Medicaid state agency will prepare and forward a claim to the appropriate CHAMPUS fiscal intermediary, which will process the claim in accordance with this INSTRUCTION.

1. CHAMPUS was established as primary payor over Medicaid on June 1, 1977, the date the new Regulation was implemented. Therefore, the following procedures will be utilized by CHAMPUS fiscal intermediaries and Medicaid state agencies in determining CHAMPUS reimbursement for beneficiaries who have received Medicaid payments for services/supplies rendered on and after June 1, 1977.

2. The Medicaid state agencies will contact the CHAMPUS fiscal intermediary to establish the specific procedures for implementation of this INSTRUCTION. Multi-state fiscal intermediaries are encouraged to negotiate uniform implementation procedures among the various state agencies with which they will be dealing.

   The fiscal intermediary and the Medicaid state agency will document the agreed-upon procedures and the contractor will forward to the Contractor Operations Branch, OCHAMPUS, a copy of the procedures and samples of the claim and payment documentation to be employed.

3. The Medicaid state agency is responsible for obtaining from the beneficiary a CHAMPUS claim

Specific Claims Adjudication Requirements:

a. Fiscal intermediaries shall verify the beneficiary's eligibility for CHAMPUS in the usual manner.

b. Only those CHAMPUS-covered services and supplies paid by the state agency will be considered for payment.

c. Timely filing requirements will be observed.

d. Claims requiring additional development will be returned to or developed through the Medicaid state agency.

e. Duplicate charge screens will apply. Where a charge was previously processed (for payment or denial) by the CHAMPUS fiscal intermediary, the Medicaid state agency will be so notified by CEOB.

f. CHAMPUS reimbursement will be made <u>solely</u> to the Medicaid state agency. Where a claim is subsequently submitted for services reimbursed to the state agency, payment will be denied as a duplicate charge, whether the subsequent claim is submitted by the beneficiary or by a participating provider.

g. Using the amount billed to Medicaid as the billed charge, the fiscal intermediary will calculate the amount which would have been payable by CHAMPUS in the absence of other coverage, that is, the CHAMPUS-determined reasonable cost/charge less cost-share and any deductible.

h. There will be instances where a <u>Medicaid-denied</u> charge is subsequently submitted to CHAMPUS by the beneficiary or provider for processing.

b. An individual or summary CHAMPUS Explanation of Benefits (CEOB) will accompany each CHAMPUS payment made to the state agency. A CEOB will not be mailed to the beneficiary or provider.

c. For each service originally paid by the state agency, the CEOB must indicate CHAMPUS payment or denial (and denial reason). Fiscal intermediaries will assure that CEOB's provide sufficient information to enable the state agency to correlate each CHAMPUS-processed claim with the agency's own payment listing.

10. The CHAMPUS fiscal intermediary will submit all payment records for claims paid to Medicaid state agencies with a "1" code recorded in position 78 in the appropriate Record 1, identifying the Medicaid state agency payee. The fiscal intermediary will exclude the charges on claims paid to Medicaid state agencies from the development of reasonable charge profiles. The fiscal intermediary will be paid the usual administrative fixed price per claim for processing each claim accepted by OCHAMPUS.

11. The Medicaid state agency or the HEW Quality Assurance staff will submit some CHAMPUS claims as a result of quality assurance reviews designed to detect the presence of eligibility for other health benefits programs. In such instances, the agency will submit the claim in the same manner as 2 above. The CHAMPUS fiscal intermediary will determine eligibility for CHAMPUS payment and reimburse the state agency notifying the submitting office of the action taken in the same manner as 8. above.

CHAMPUS fiscal intermediaries should direct any questions concerning these instructions and procedures to the Contract

to be a CHAMPUS beneficiary, CHAMPUS shall reimburse the appropriate Medicaid agency for such amount as CHAMPUS would have paid in the absence of Medicaid benefits, under the following conditions:

"a. Reimbursement Requirements: The documentation required in order for CHAMPUS to make reimbursement to a Medicaid agency shall be established by the Director, OCHAMPUS (or a designee), and must provide sufficient information to permit the proper determination of the applicable CHAMPUS benefit.

"b. Time Limit on Reimbursement. It is the responsibility of the appropriate Medicaid agency to determine such other health and medical coverage under which a Medicaid-eligible person may also seek reimbursement for medical services and supplies. In order to receive reimbursement from the CHAMPUS Program for Medicaid benefits paid in error on behalf of a person subsequently determined to be a CHAMPUS beneficiary, the appropriate Medicaid agency must submit a request for the reimbursement no later than December 31 of the year following the year in which the medical service and/or supply was provided."

Responsibilities: A reopening of discussions between the Department of Defense and the Department of Health, Education and Welfare has resulted in agreement upon the claim filing procedures outlined in this INSTRUCTION, which are to be followed in order to reimburse Medicaid for payments made in error on behalf of CHAMPUS beneficiaries.

Medicaid Bureau Quality Control staff of the Health Care Financing Administration are encouraging all Medicaid state agencies to emphasize detection of other insurance or health benefits program coverage prior to payment of a Medicaid claim. When such claims are detected, the Medicaid state agency frequently

form with the top half properly completed (including appropriate signatures).

The CHAMPUS fiscal intermediary will furnish a sufficient supply of CHAMPUS Form 500 to the state agency.

The requirement for itemization of services may be satisfied by any agreed-upon means, e.g., Medicaid itemized claim, claim service data printout, etc., as long as the method provides sufficient information to allow the CHAMPUS fiscal intermediary to determine benefits consistent with CHAMPUS instructions.

4. The CHAMPUS claim form with attached service itemization will be forwarded to the appropriate CHAMPUS fiscal intermediary. For each claim so submitted, the Medicaid state agency will provide two copies of a payment listing which contains, as a minimum, the following information: the specific services paid by Medicaid, the amount of the payment for each service, and the individual to whom the payment was made.

   The information contained in the state agency's payment record retained for audit purposes will usually satisfy this requirement.

   Each payment listing must be certified as accurate by a responsible State Agency Official.

   Where high claim volumes are encountered, the claims are to be forwarded by the state agency in batches of 50, accompanied by the copies of the payment listing for each batch.

5. CHAMPUS fiscal intermediaries will process all state agency submitted claims in accordance with all applicable CHAMPUS requirements, limitations, and definitions.

Since the charge was denied by Medicaid, CHAMPUS reimbursement to the state agency would not have been made and the charge may be processed by the fiscal intermediary in the usual fashion.

6. The amount of the CHAMPUS reimbursement to the Medicaid state agency is limited to the lower of:

   a. The amount of the payment made by the Medicaid state agency; or

   b. The CHAMPUS-determined reasonable cost/charge, less normal deductible and cost-share.

7. In most cases, the Medicaid-approved charge is less than the CHAMPUS-determined reasonable charge. Providers often bill Medicaid only for the amount which Medicaid allows. Providers may not then resubmit the claim to CHAMPUS for an adjustment to the higher potential CHAMPUS-determined reasonable charge. Such claims are to be denied as duplicates.

8. The Medicaid state agency, in order to be eligible for payment, must agree to accept the lower of the Medicaid payment or CHAMPUS-determined reasonable cost/charge, (less any deductible and cost-share), as full payment for services rendered to CHAMPUS beneficiaries.

9. The CHAMPUS fiscal intermediary is accountable for effective control of all claims submitted by the Medicaid state agency and for reporting to the state agency the CHAMPUS determination made on each claim.

   a. Where possible, the fiscal intermediary will issue a summary check to the state agency for all claims processed during a payment cycle.

Operations Branch. The fiscal intermediary must notify the Contract Operations Branch and obtain advance approval for any deviations from these instructions.

EFFECTIVE DATE OF IMPLEMENTATION

These instructions are effective on a date to be mutually established by the CHAMPUS fiscal intermediary and the Medicaid state agency. No claims are eligible for payment consisting of services performed prior to June 1, 1977. Under transitional authority (DOD 6010.8-R, Chapter I.N) the timely filing requirement, as specified in DOD 6010.8-R, Chapter VII.D., Claims Filing Deadline, shall not apply to Medicaid claims covered by these instructions for services performed from June 1, 1977 through December 31, 1977. OCHAMPUS has notified HEW of these procedures and instructions and HEW will notify the state agencies. The state agencies will contact the CHAMPUS fiscal intermediary to establish implementation. The CHAMPUS fiscal intermediary will notify OCHAMPUS if the date of implementation proposed by the fiscal intermediary is not acceptable to the state agency. The CHAMPUS fiscal intermediary, also, will notify the Contract Operations Branch in writing of the agreed-upon date of implementation.

M. R. TANNER
Captain, MSC, USN
Acting Director

DISTRIBUTION:
A - CHAMPUS Contractors
B - DOD, Primary List
C - Supplemental List
D - OCHAMPUS Internal
CHAMPUS/Health Benefits Advisors/Counselors:
E - Army
F - Navy, Marine Corps
G - Air Force
H - Coast Guard, U.S. Public Health Service, National Oceanic and Atmospheric Administration

DATA COLLECTION and PROVIDER RELATIONS

Steve McClain

Assistant Project Manager

Systems Architects, Inc.

Today is devoted mostly to talks by people from Systems Architects, Inc. Systems Architects is the contractor-firm which seeks to help the Corrective Action Project Division (CAPD) teams provide technical assistance of various sorts to the State Title XIX agencies. CAPD and Systems Architects are performing a variety of chores in trying to enhance Medicaid program efficiency. These include: consulting work, designing management information systems and management reporting systems, help in installing error prone profiling systems, and designing, implementation and evaluation of these systems. Finally, a major area in which CAPD has become involved is in assisting the development of systems and evaluating systems to help collect money from liable third parties. The task that's most germane to this conference is the one embracing the writing of the third party liability guide, a how-to-do-it guide designed to show the State agencies how to devise optimal systems for collectng monies from third parties.

In order to prepare materials for this guide, we traveled to five States, Washington, California, Maryland, Minnesota and Michigan, to see how TPL systems had been implemented under a variety of settings. We were looking for successful practices and ideas that could be incorporated into model systems and publicized in the guide. A first draft of this guide has been presented to the Health Care Financing Administration, and the final version should be available shortly.

The bottom line for this discussion is data collection. It's MSA's opinion as well as the State's that if you do not have the information you need to do third party benefit recovery, you're not going to progress very far, regardless of whether you have the best automated data processing system or the best third party benefit recovery unit in the world. Therefore, the first topic of discussion will deal with the different methods of collecting data. There are three basic methods to collect data.

The first one takes place in your local social services office during the application intake. The second alternative is to mail for your data regarding third party benefit recovery health insurance, casualty insurance, whatever. You can do a mail-out to people who are found eligible for Medicaid benefits. The last is the combination of the two.

There are several advantages to collecting third party data at the local office. The obvious one is that your caseworker has the applicant in the office. The caseworker can make sure that the data is complete and they can assist the person in filling out the application, if they need help. Secondly, it's found from State experience that when you have the actual person in the office with the caseworker, the person is more likely to be cooperative because they are concerned about getting their Medicaid benefits. Another advantage is speed. You immediately have that information available for your central office at the intake process.

The mailing-out of data, on the other hand, has the time saving advantage of mailing data or questionnaires for third party benefit information only to those people whom you have actually found to be eligible for Medicaid. The problems States have found with mailing-out for information are: 1) After you mail it out there are delays in getting the information back, and 2) often the information returned is incomplete or inaccurate, and therefore, useless.

In the Third Party Benefit Recovery Guide we will recommend that you try to gather as much information at the intake as you possibly can, and that you mail only in those instances where it is necessary: instances such as the 1634 State arrangement, which will be dealt with later, or where the data that you need at the local office is unobtainable. The person neither knows nor has the information with him or her. In many States, when people come in to set up an appointment for Medicaid application processing, the caseworker gives out a handout sheet on which the applicant is told the type of information needed, such as social security, kind of health insurance policy they may have, whether they are presently injured or have any medical problems. They may also be requested to bring in documents and reports from their doctors. The requirements are detailed in the guide. This is only a brief overview.

In the guide, we recommend and prefer a two step process. The first step is your basic eligibility determination for Medicaid or redetermination, whatever the case may be. On your eligibility application, you have two questions outlined here which are pertinent to third party liability. These questions are numbers 33 and 35.

The first box talks about whether one's a veteran or non-veteran. The second box talks about any kind of medical resource. There's a box in each case for none, Blue Cross, Blue Shield, CHAMPUS, State employment program, Medicare A or B, or other.

When the caseworker fills out the application, if there is no positive response to any of the questions, no other application needs to be completed. If, on the other hand, the person has a positive response to any of those questions, then the individual fills out a Medical Resource Documentation Form (MRDF). Developed in Pennsylvania, this is thought by us to be an adequate resource form and is used in the Third Party Benefit Recovery Guide as an example. Again, the guide is not an absolute. You do not have to use it; however, we do suggest that these are the points that you should cover in whatever form you develop for your State.

If you look in the left hand corner you can see it is divided up into about five different basic groups of information.

The first group deals with basic applicant information or identification. It includes things such as name, social security number, birthdate, county code, record number, etc.

The second group of vital information regards health and casualty insurance. This reflects things such as type of insurance, name of insurance carrier, claims office address, group contract number, etc.

At this point it should be said that based on your hearing the Health Insurance Association of America presentation yesterday, these data elements in the guide do meet HIAA requirements for getting prompt recovery from the health insurance industry. Of course, these data elements taken at the intake must be combined with the medical services information obtained on your provider invoice. However, the combination of the two will provide you with the data elements which HIAA requires in order to process third party recovery claims from the State.

The third group is employment information, and worker's compensation.

The fourth group is absent parent information, IV-D, and then union information, in case some kind of union health benefit is involved.

Once this basic data is gathered, either via hard copy, which is your basic application form, or by cathode ray terminal (CRT), it should be processed to the central office. We recommend in the guide that you use the MRDF which is also the input document that goes to the central office. That way, there is no transference of information from one another. Whether via CRT or hard copy, the eligibility information application goes through quality control which is, in effect, a supervisor situation within the local or central office. Data processing then takes it and updates the eligibility file. The MRDF also goes through a form of quality control. Again the supervisor checks it for completeness and accuracy. The information is sent through to data processing at the central State office and serves to update the third party liability file.

In the guide, unusual data collection situations are also discussed. This might be for probate. Or there might be a lump sum court settlement that would be missed by central office but would be spotted by the local office. We have generally recommended that some type of procedures be set up where phone calls may be made by the local office to the central office for these situations.

One situation that I have discussed only briefly is the situation where local office data collection cannot be done. This is a 1634 State. I'd like to touch upon what the 1634 State situation is for those of you who are unfamiliar with this.

Under the Social Security Act, the SSI program was set up. This provides cash assistance to the aged, blind and disabled. States may, at their option, set up a criteria for the aged, blind, and disabled for Medicaid which are more stringent than those set up by SSI. On the other hand, the State may opt to use the same criteria for the Medicaid aged, blind, disabled as that which SSI uses. If the State uses the exact same criteria for both programs, it may, under Section 1634 of the Social Security Act, have the Social Security Administration determine eligibility for Medicaid for that group of people. These States using the same criteria for both programs are referred to as 1634 States. They have contracted with the Social Security Administration to make their Medicaid eligibility determination. This should help that State financially. However, one problem with third party remains. How do you discover third party data on people who are found eligible by the Social Security Administration? The obvious answer would seem to be: get Social Security to ask those questions for you. However, Social Security is reluctant to ask those questions for you. The only question the Social Security Administration asks is number ten, on page one of the Social Security application for SSI. The question reads: Do you or any children in your household have Medicaid or other health insurance or medical coverage from Veteran's Administration, worker's compensation, accident insurance or any other source? You get a "yes" or "no" response on that. The Social Security Administration sends out a SDX, a State Data Exchange tape. You have a "yes" or "no". Now if that's all the information you've got on that individual and you receive a "yes" response, you're going to have to send out for additional data in order to update your TPL file.

What we've used is a model mail-out form for 1634 States. This may also be used as a backup form, if, in fact, the caseworker doesn't get all the necessary information, or if there is something suspicious about the information and you want to check it out. The form we have used is designed by the State of California. It covers the basics that I've outlined for you on the Medical Resource Documentation Form.

The guide also includes a section on caseworker relations. We believe this to be very important, particularly when dealing with third party benefit recovery system in a State, because it demands additional workload on your Medicaid eligibility redetermination. Some States have met a certain amount of resistance from their caseworkers for having to fill out additional forms. They argue that they are overworked and have enough problems and responsibilities on their hands without needing additional workloads. Thus, we feel it's extremely important that there be proper and adequate training manuals and information needed in order to do the job properly with the least amount of frustration and disillusionment. They must also understand why they're doing the work -- its purpose and goals.

Michigan has set up a system whereby someone in the third party benefit recovery unit will biannually go through and help figure out what local office was responsible for what amounts of recovery. This is done by aggregating certain amounts of data as far as amounts recovered. Then at set intervals, a letter will be sent to the local office's manager and they'll say, "We just want to compliment the caseworkers on the fine job that they have collected or that we have collected here at the central office; hundreds of thousands of dollars in the last few months due to their efforts." When we went out to the local offices, the caseworkers knowing about the little letter that came in every so often were kind of pleased about that. It gave them positive feedback. It doesn't take too much trouble on the part of the central office to do these types of things.

Caseworker training should be done in a central location, and whatever your training situation is, it should certainly be part of your overall Medicaid training package. The minimum training that they should have is a legislative history of the State's third party benefit recovery program, so they understand the statutory basis and why it is not just something that the single State agency created through regulation. They should also understand that the insurance companies are frequently the third parties. What we are trying to do is place the burden where the burden should be. The workers should understand how the information is utilized by the third party benefit recovery unit. They should be given a thorough rundown on all the forms that will be used and how those forms will be processed in the central office. They should also be given thorough and accurate examples. We have in the guide a whole section dealing with the sources of third party recovery. They should understand both casualty insurance and tort liability. They should understand what probate is and what basic health insurance coverages are. Last, but not least, they should have an organization chart of the third party benefit recovery unit in the State office with a list of resource phone numbers, so they can know whom to call if there are any problems.

We also think the casework manual is invaluable. We think there should be a separate section for third party benefit recovery in the manual. We have concluded in the guide what we consider to be a fairly good model of what a

manual section should cover. Again, the manual would have to be adapted for each State's needs. It's fairly obvious what we think it should have. It should be clear and have detailed instructions on gaining and transmitting third party benefit recovery data. Also, attempts should be made to insure that it is kept up to date. Finally, in reference to data collection, we recommend two basic management reports in the guide.

The first two reports are developed from data gathered from the caseworker by the supervisor. The supervisor responsible for the local office worker goes through those forms, looking for inconsistencies between responses on eligibility, the MRDF, etc. Where there are inconsistencies, they should take action to correct the problem.

Somebody in the third party benefit recovery unit should have the responsibility of taking information collected by the supervisor. They can generate reports to see, in an aggregate way, what kinds of errors are actually being made in the local offices. Then, based on that information, try to figure out where you are going to have problems. If you have a no-fault State and you know, for example, that something like 10 or 15% of your Medicaid population have cars, and have to have insurance, but this isn't showing up in your local worker's intake information, then you should probably address it more strongly in your training packages, Statewide memos, and updates to your manual.

The second type of report would be something of a recipient TPBR profile based on your Medicaid population. It would be necessary to set up some kind of software package, a little computer program that would aggregate and give you percentages of the type of third party resources identified for each Medicaid recipient, and have this printed out on a hard copy. Again, an example might be the number of Medicaid recipients with no-fault or regular automobile insurance, the number of Medicaid recipients with health insurance, recipients with employment, or the number of Medicaid recipients with law suits in progress. You might create a listing of items which would provide some sort of notion, in an aggregate and percentage way, what your Medicaid population looks like in terms of third party benefit recovery. Then, if these don't agree with what you may think might be out there, there are things you can do to determine what the recovery ratio should be; make changes in your Medicaid policy and the development of your guide, caseworker manual, or training packages to place greater emphasis on those areas. Those are the two types of reports that we think would be helpful to management in an overview of data collection.

When discussing topics, Systems Architects, Inc. and CAPD decided that there should be something said about provider relations as well as data collection. We felt it was important to deal with that because some States have found that if they get off on the wrong foot with providers when they are initiating a third party benefit recovery system, everything else gets unorganized. Dealing with providers through the Medicaid program is a complicated situation. It can be exacerbated by many things, depending on how much the State pays its provider population and how many doctors are available, etc. Third party benefit recovery certainly impacts on that.

There are essentially two major types of third party recovery systems which are mentioned in the guide. They both impact differently on the provider relation. One is the cost avoidance system which you have heard

people talk about. Essentially, for those of you who are not familiar with this term, cost avoidance is where you have a data base carrying basic information on the presence of third party resources. You receive an invoice, a bill, from a provider (a physician, hospital, or dentist in States that cover dental). When that bill comes in to the claims processing system, you will run that invoice against your data base. If it indicates that there is a third party resource available to take care of whatever services provided and indicated on the invoice, then you will return it or adjudicate it. You will go through a certain process with the invoice so that you will know how much of an expenditure is involved, or you would immediately return it to the provider with the basic information about third party resources attached and make the provider responsible for going after the liable third party. When the provider receives payment, the case would be closed because he or she has been paid for the service by the health insurance company or whatever.

In some instances where the provider feels that he or she will not receive or recover anything from the third party, or the third party information is false, or if there is only partial payment (where there's health insurance and a deductible), he or she will return the claim back to the State and the State will pay the provider. The State will then have the obligation to go after the responsible third party. Restated, in the cost avoidance system you avoid paying the cost of the third party; from the very beginning, the responsibility is placed on the provider to go after the third party involved.

The second possible system for third party benefit recovery is the post-payment system. This is a system where you have your third parties available. You receive an invoice from the provider, and data processing takes the claim through the system, figuring out what services should be paid, and generates a check to the provider. Next, the State goes after the liable third party (Blues or casualty insurance, etc.), and takes them through the process. In this way, as you can see, there are some advantages and disadvantages.

In the cost avoidance system it is extremely important to have very good procedures and to be very organized. It's also important that you work with a clean data base. The information must be updated and accurate. Otherwise, you will generate back to the provider false or inadequate information. He or she will go after the third party which will be uncooperative and then the provider will become agitated about the whole situation. A lot of emphasis is placed on the State to be organized in relation to third party information.

The post-payment system relieves this problem to the extent that they generate the checks to the provider, and the provider is paid in a very timely fashion. It is then up to the State to pursue the third party.

The cost avoidance system is advantageous in that it is cheaper for the State, and it does not tie up a lot of State money while you are chasing third parties after paying the provider. It does not require a large accounts outstanding record-keeping procedure, nor does it require a large recovery case tracking system, as does the post-payment system.

There is also number "42", Emergency Code, which indicates the types of services provided. These include the following services: psychiatric,

drugs and alcohol, methadone, partial hospitalization, surgical, home health care, laboratory, ambulance, radiological, X-rays, etc. It's a catchall for people to indicate exactly what was done.

Other ones are things like whether the person has Medicare, Title XVIII coverage, insurance paid by another carrier or by a private carrier, Title XVIII deductible, Title XVIII co-insurance, the total amount charged by the provider, the total amount Medicare approved, and the total amount billed. This is the kind of information one must have on any kind of invoice. Most of them are self-explanatory. We also have another form for dental, which we are not going to go through because it repeats many of the things I have said with some slight additions. As far as the guide is concerned, if you need some kind of model invoice form, we think that this one covers the necessary points.

The guide recommends, as an optimal system, a hybrid between the cost avoidance systems and the post-payment system. We think that certain kinds of third party resources lend themselves to a cost avoidance system, and the responsibility should be put back on the providers to pursue the third party. Other types of third party resources, because of the time elements involved, do not lend themselves to the provider trying to recover it. The State should take that burden off the provider.

What we have come up with in the cost avoidance, or hybrid, system is that you can have rejected claims. In other words, in a pure cost avoidance treatment of a claim, the rejected claim is sent back to the provider. We feel that the types of sources that lend themselves to that are things like health insurance because it is easily identified; you have the necessary information. In States with no-fault insurance, we feel that is a good one to go after as far as cost avoidance goes. With States that have a fairly well organized IV-D program or absent parent program, that also can be a good one to cost avoid. Pended claims are things that should be looked at and may be considered for post-payment billing. Anything that you pend, if it is going to take time, should probably be post-payment. It is our opinion that an ICDA code, accident code, that requires investigation by your third party benefit unit, should have the State generate payment as soon as possible, and then go after that on their own. That would also include things like tort claims where there is going to be some kind of legal intervention and court settlement involved. In worker's compensation, depending on what is available, you might want to do a crossover. In the cost avoidance system, rejected claims, per order from the Health Insurance Association of America, must have an attachment on them to the provider. You will send back the invoice the provider gave you and then attach it to that invoice. Usually it is automatically generated. It must have certain information on individual policies. These are what we got out of the HIAA requirements. The requirements include the ID policy number of the patient for the individual policies. It is different for individual policies and for groups. You have to have proper claim documentation, a listing of the services, the patient's name, the policy holder (if other than the patient), policy number, social security number, and the date of birth. For group policies HIAA has asked us to require the group policy number, the name of the group policy holder, the plan number, the full name of the person insured if it is not the patient, the date of birth, the employer's ID, the social security number, and the work location.

We feel that regardless of what kind of system you use, if you try to go the cost avoidance way, which is recommended in the guide, you are putting an additional burden on your provider. The burden is on the provider because he/she will be generating a bill, and then you will be sending it back. He/she will then have to go after the third party. We feel that in order to maintain good provider relationships, some States with very large cost avoidance systems (like Michigan) must set up good provider training and provider manuals. We think a provider telephone hotline (for immediate feedback), written provider inquiry procedures, and, if you need it, in-person inquiry procedures should be available to keep good relations. The point we are trying to make: if you are going to go cost avoidance, which is a viable way to go in some third party resource types, you must be very careful to lay a strong framework, and make sure the ground between you and your provider population is stable. Some States have had a certain amount of hostility generated. These kinds of things have to be developed for your provider population in order to alleviate hostilities.

I should also indicate that if you are going to go to a cost avoidance system, one State we talked to said that it is very helpful to set up well publicized meetings with your provider population to discuss this and whatever it is that you are planning. Another State advised not to call meetings, but rather to send out notices because these meetings get very hot and heavy. The guide's stand is that the more honestly you pursue it with the provider population, in the long run, the better the relationship and the smoother the transition will become.

QUALITY CONTROL

Michael Skutar

Manager, TPL/Quality Control

Michigan Department of Social Services

My name is Michael Skutar, I'm with the Department of Social Services Quality Assurance Office in the State of Michigan.

I'm going to begin my presentation today by quoting Calvin Coolidge. Coolidge said the easiest thing in the world to do is to spend public funds because there is so much of it available and it doesn't seem to belong to anyone. When we compare the current Medicaid national budget with the first Medicaid budget, we find that there is a lot of wisdom in Coolidge's words.

In Fiscal Year 1980, which begins in October, the United States is slated to spend $22.3 billion on the Medicaid program. Twelve years ago, the Medicaid budget was somewhere around $3 billion. It is, therefore, obvious that Medicaid is experiencing spiraling costs. These costs are compounded by misspent dollars. These misspent funds results from errors in (1) eligibility determination, (2) fraud and abuse -- that is fraud and abuse on the part of both recipients and providers, (3) claims processing -- errors occur in claims processing whether you have an automated system or a manual system, and (4) third party liability.

The Medicaid quality control program deals with three of these areas. Eligibility determination, claims processing and third party liability. Since this is a third party liability workshop, I am going to confine myself to that subject. Moreover, I will relate to you what we are doing in Michigan with quality control third party liability.

For the most part, however, you are going to find that they are doing virtually the same thing in all fifty States in the area of quality control.

For the purpose of Medicaid quality control review, third party liability may be defined as "those unit resources which are available from both private and public health insurance, and from other liable third parties, that can be applied toward Medicaid beneficiaries' medical and health benefit expenses." The purpose of third party liability review is to assess the effectiveness of Medicaid program administration as it relates to third party recovery. The review provides the following findings. First, were third party resources available to the beneficiaries during the review month? Second, if third party resources were available, was that fact known to the State's Title XIX agency? Third, if third party resources were available, were they fully utilized? Fourth, if available and fully utilized, how much was inappropriately paid by Medicaid?

Through the review of third party liability cases, we expect to determine the effectiveness of the third party liability unit in recovering Medicaid funds from liable third party resources. We take into consideration compliance with Federal and State policy, cost effectiveness of the methods employed and completeness and timeliness of the recovery, or attempt to recover.

Cases are randomly selected from the AFDC population, from the MA only population, and from the SSI population. Our monthly sample in Michigan consists of 240 SSI cases, 200 AFDC cases and 100 MA only cases. Six months after the sample month, we draw all claims which were paid by Medicaid for recipients who are in the sample. These payment records are taken from the

Michigan MMIS history file and assembled in report form for each third party liability case. Cases are then reviewed for appropriate payment of claims and for appropriate processing of third party liability recovery. The information indicating the presence of a third party resource is gathered during our eligibility field review. At that time, we attempt to complete resource identifying information.

I would like to show you a copy of a form that we use. This form (Exhibit 1) is our revised form of the HCFA 301-C.

The 301-C is the HCFA form which was designed for the field auditor to record the third party liability information for transmittal to the third party liability quality control unit. We found that the form that was given us by HCFA was inadequate for our purposes. We just couldn't use it. It wasn't asking for enough information or the right information.

You have seen a thousand forms during this three day session; here is another one to add to your collection. We find this form very effective, by the way. Before we came out with the form in October, we had used the HCFA 301-C for three months, and we were getting very little data concerning third party. We trained our field auditors in interrogating for third party resources and gave them this form. It is producing quite a bit of information. Twenty-six percent of our AFDC cases are showing insurance information or medical support, 50% of our MA only cases are showing supplementary health insurance, and 51% of our SSI cases. This information at the top of the form is inhouse information. We have each individual recipient's name here, and their benefit code. If it is health insurance you put an "A" next to the recipient. If the recipient should have more than one resource, then they will put more than one code down. Then the recipient's individual ID number is indicated here. This is all filled in by the field auditor. If the recipient has health insurance, then all of these data elements are what the health insurance industry requires in order to identify their policy; the name of the insurance company, if it is Blue Cross, Blue Shield, and the service code. The service code is important because this code really breaks out the specific policy that has been issued to this individual.

That's a code that the Blues can read. The effective date of coverage, the name of the policy holder, the group, control or policy number and if the group, control or policy number are synonymous. Some insurance companies call it policy number, others call it control number, still others call it group number. You will find that in addition to the group, control, or policy number, you are going to have a contract or certificate number. That is usually an individual's social security number.

All of this information is important because ultimately we will go to the insurance company and find out whether or not these services were covered and if so, to what extent they were covered. We would also ask how much their liability is for these services and whether it's a policy that is through a union or a fraternal organization. If they have Medicare coverage available, then we would ask for their number and go to the Medicare fiscal agent to establish the exact amount of coverage available to them for the specific service. We have good rapport with them. If there are veteran's benefits, then we gather the information that is needed. I think you are all aware that in the case of veteran's benefits, if you don't take advantage of

Exhibit 1

MEDICAL SERVICES AND HEALTH BENEFITS WORKSHEET SUPPLEMENT

Michigan Department of Social Services

1. Case Name	
2. Case Number	3. MQC Review No.
4. Local Agency Code	5. Auditor's No.

PLEASE PRINT

I. IDENTIFYING INFORMATION

6. Case Address (No., Street and City)	7. Category ☐ ADC ☐ SSI ☐ MAO	8. Review Sample/Mo.	9. Date of Review

10. SSI Case Completion Status ☐ Eligible ☐ Ineligible ☐ Excluded/Dropped	11. SSI Stratum Code FFL: 1 ☐ 2 ☐ 3 ☐ Non-FFL: 2 ☐ 4 ☐ 6 ☐	12. Case Phone No. (Area Code, No.)

13. Using the codes listed below, indicate the type(s) of medical care benefits available to each case member. If a case member has no medical care benefits available, use code "0" Complete the corresponding section of the form for each health care benefit code used. If more than one of the same type of health care benefits is available, use a separate form so that the second benefit may be completely identified. For example, if the case members have more than one health insurance, use additional forms. Code all types of benefits available to each case member. If space provided is not sufficient for listing all case members use additional forms.

A - Health Insurance
B - Government Programs
C - Work Related Illness or Injury Coverage
D - Motor Vehicle Accident Coverage
E - Other Accident Coverage
F - Court ordered Medical Coverage
0 - No Coverage Available

CASE MEMBER NAME	BENEFIT CODE	RECIPIENT ID NO.

Note: Complete only the sections below which apply. If all case members have a health care benefit code of "0", DO NOT complete the balance of this form.

II. HEALTH CARE COVERAGE INFORMATION

Section A. Health Insurance

1. Name of Insurance Company	2. Service Code (BC/BS)	3. Effective Date of Coverage
4. Name of Policy Holder	5. Group, Control or Policy Number	6. Contract or Certificate Number

7. Is Health Insurance Through The Policy Holder's (Check appropriate box)

☐ Employment (Give Employer's Name and Address) ☐ Association/Fraternal Org. (Give Name and Address) ☐ Union (Give Local No., Name and Address)

Section B. Government Program Health Care Coverage (Not Medicaid)

Medicare (IF SUPPLEMENTAL INSURANCE EXISTS, IDENTIFY IN SEC.A).		Veteran's Benefits		
1. Claim No. ID	2. Coverage(s) Available ☐ Part A Hosp. Ins. ☐ Part B Med. Ins.	1. Name of Veteran	2. Social Security No.	3. V.A. Claim No.

CHAMPUS (If Coverage Is Available, Obtain Responsible Case Member's Signature on One Copy of Champus Form 1863-1, 1863-2 and 1863-4)

1. Name of Military Service Sponsor		2. Sponsor's Social Security No.	3. Effective Date	4. Expiration Date
5. Branch of Military Service	6. Military Service No.	7. Military Service Grade	8. Duty Status (Check one) ☐ Active ☐ Retired ☐ Deceased	

9. Organization of Sponsor and Duty Station (Home Port for Ships and Address for Retirees)

10. LIST COVERED DEPENDENTS

Name	Champus ID No.

Other Government Programs - Identify any other government programs from which a case member has health care benefits available. Provide complete identification.

DSS-2156 (8-78)

Page 1

MQC Review Number

Section C. Work Related Illness or Injury

1. Name of Employer	2. Address of Employer	
3. Name of Recipient's Attorney (If applicable)	4. Address of Recipient's Attorney (If applicable)	
5. Work Department (If applicable)	6. Claim Number	7. Date of Illness/ Injury

8. Describe Illness/Injury

Section D. Motor Vehicle Accident

1. Determine available auto insurance in order of priority. Check only the first source from which auto insurance is available on the list below.

A. ☐ Recipient B. ☐ Relative in Household C. ☐ Vehicle occupied D. ☐ Other vehicle

2. Name of Person with Auto Insurance	3. Address of Person with Auto Insurance	
4. Name of Auto Insurance Company	5. Place of Accident (City, County, State)	
	6. Claim Number	7. Accident Date
8. Name of Recipient's Attorney (If applicable)	9. Address of Recipient's Attorney (If applicable)	

10. Describe Injury

Section E. Other Accident

1. Person who caused accident/Owner of Premises	2. Claim Number	3. Accident Date
4. Responsible Person's Insurance Company	5. Address of Responsible Person's Insurance Company	
6. Name of Recipient Attorney (If applicable)	7. Address of Recipient's Attorney (If applicable)	

8. Describe Injury

Section F. Court Ordered Medical Support

If a court order has been issued as the result of a divorce judgement or in the case of civil support, or paternity action and medical support or confinement expenses are included in the order: OBTAIN A COPY OF THE SUPPORT ORDER AND ATTACH TO THE MEDICAL SERVICES AND HEALTH BENEFITS WORKSHEET. IF A COPY OF A COURT ORDER IS PROVIDED DO NOT COMPLETE ITEMS 3-8.

1. Person Ordered to Pay Medical Expenses	2. Address of Responsible Person			
3. Type of Court Order ☐ Probate ☐ Circuit	4. County of Court Order	5. State of Court Order	6. Court Order No.	7. Effective Date

8. Type of Court Action

☐ Divorce ☐ Civil Support ☐ Paternity (Confinement) ☐ Other (Identify)

Remarks:

9. Name of Absent Parent's Employer	10. Address of Absent Parent's Employer (If known)

NOTE: If absent parent provides health insurance coverage for any member of the case, please identify in Section A.

Comments:

it on the front end, Medicaid will not be able to recover it from the Veteran's Administration. This is actually a cost avoidance area with which quality control doesn't deal presently, but in the future it may change.

If it is CHAMPUS, then all of the data elements asked for here are required by CHAMPUS. They need the name of the military sponsor and social security number, as well as the effective and expiration dates, the branch of military service, the military service number, the military service grade, duty, status, etc. Other required data include the covered dependents. All the above information is available on the CHAMPUS card. Other government programs and local government programs might also offer medical care or pay for the cost of medical care.

Question: On the form, do you have a "services rendered" section?

Answer: Services rendered is not necessarily on this form. This form is used by the field auditor who identifies the insurance company. The insurance company lays out the services rendered. You must have services rendered when you go to an insurance company, but this form is for general purposes. It is not used to communicate with the insurance company. What you have in mind is the 301-C. This is the Federal form which shows the services rendered. We deleted it because it was unnecessary and confusing since the information is already in our system.

At the upper back side of the form, we have a section on work related incidents. If that recipient has a work related accident, then we have a worker's compensation section. If it is a motor vehicle accident, we have the motor vehicle section. The questions asked in the motor vehicle section are unique to Michigan's no-fault law. If you were employing a form similar to this, you wouldn't ask these specific questions. However, we must find out who the primary carrier is in the case of an auto accident. According to Michigan's no-fault law, the primary carrier would be the individual's own auto insurance policy. However, if the individual does not have an auto insurance policy, then you would go to that individual's relatives residing in his or her household. If they have an auto insurance policy, that would be the primary policy to cover his or her injury, regardless of the degree of injury or ownership of the car. If the household doesn't have any insurance, then you move to the car in which he/she was riding. Look to the owner of the car and the driver. There's a whole list of priorities in the Michigan no-fault law. Ours is designed to accommodate them.

If the recipient was involved in another accident, or you had another type of claim, malpractice, product liability, or homeowner's claim, the field auditors would then seek information regarding these coverages. We have court ordered medical support. This is specific information we need in determining the extent of liability of the absent parent. Again, we have the person, who is the absent parent ordered to pay the medical expenses. We had the address of that person, the type of court order, and the county in which it occurred. The court order may not have been ordered in Michigan, so we must know the State, the court order number, the date of the court order, the name or the absent parent's employer, and the type of legal action, whether it is a divorce, civil support, or other.

Question: Do you have to have anybody's permission to substitute your form for the HCFA form?

Answer: If we did, we'd still be waiting. We just went ahead with it and it is working.

Question: Can they use any form they want?

Answer: Yes.

Question: Are you a 1634 State?

Answer: Yes, we are.

Question: SSI does this for you?

Answer: No. SSI won't do this, we've had communications back and forth with SSA concerning this form. They're still sending us the 301-C. Therefore, we're getting relatively little information on other insurance on the SSI cases. And I feel that the inadequacy of the 301-C form is the chief cause of it.

Comment: We had problems in Region I. The State complained that the 301-C is not completely filled in by SSI.

Comment: From the way the 301-C is designed, I can't blame SSA for not filling it out.

Question: I may be anticipating a point with you, but won't we be guilty of an error under quality control procedures if, on a SSI client, we fail to find something that was not given to us by SSA?

Answer: I don't think so. I don't see how they can. They can't burn you for that.

Question: You're a 1634 State?

Answer: Yes, we are, but as this gentleman said, we don't get much unless you get it through independent means. I don't think they can burn you for using the information SSA gives you. If it's inadequate, it's inadequate. It's up to HEW to resolve that problem.

Question: If the client had insurance, but the State didn't know about it because it was not relayed by a SSA agency, could we declare it?

Answer: I'm sure you could. I can't speak for HEW, but I know they wouldn't withhold FFP in Michigan if they tried that.

Question: In your opening remarks, you mentioned that 51% of the SSA recipients had some form of TPL. What percentage of that is Medicare?

Answer: I would say all of it is Medicare, a combination of Medicare and supplementary insurance. I would say 51% is Medicare. I haven't seen one SSI yet without Medicare within that 51% group. I think the percentage of SSI recipients with Medicare or health insurance is over 51%. The 51% is based on the first six month figure. You've got to keep that in mind when we use any information we get from SSA. I talked to someone a few weeks ago in

Massachusetts and found 70% of SSI recipients had other resources. As far as distinguishing Medicare and health insurance, I can't say. I could tell you for sure if I was back in the office and had the figures on the breakdown in front of me. They break it down into other categories according to the type of health insurance and the insurance carrier. We also investigate the turnaround time for verifying the length of time it takes a particular insurance carrier to respond to us.

Let me recap what we do. First, we draw samples, 540 cases each month. Second, our field auditors go out and interview the recipients on these cases. During these interviews they inquire about other resources. They ask to look at insurance policies and insurance identification cards. They also inquire about employment and check with employers and former employers about available insurance. They obtain copies of divorce decrees and support orders. They inquire into the availability of all types of coverage from Medicare to CHAMPUS. They even go to the extent of asking if any member of the household was injured in an accident recently and is receiving medical care for that injury. Third, the field auditor transmits the third party liability data to our office via this 2156 form. Fourth, at the end of five months, following the sample month, our computer generates a detailed report of all medical claims paid for services rendered to recipients during the sample months. Fifth, our third party liability reviewers go to the third party liability unit to examine their files to determine what activity, if any, has transpired with respect to seeking recovery from the third party resource. Sixth, we then contact the insurance carrier or other third party resource to verify the extent of liability -- finding out the exact dollar amount they cover.

Let's take a look at the Federal definition of a third party liability error. A third party liability error exists only when all of the following conditions are met: 1) there is conclusive evidence established by the quality control reviewer that a third party was obligated to pay for services received by a beneficiary during a review month; 2) Medicaid actually paid for the services for which a third party was liable; and 3) Medicaid did not recover or seek to recover the available third party funds within 30 days following the month in which the claim was paid. Now let's go over these various elements.

Evidence of third party resource. It is critical to the integrity of the third party liability review process that the quality control reviewer demonstrate and document the obligation of the third party to pay for medical expenses incurred by the Medicaid beneficiary during a review month. For example, it is not sufficient to demonstrate that a beneficiary had other health insurance coverage during a review month. There must be conclusive evidence that the available insurance would have covered the specific service for which Medicaid paid. In addition, the reviewer must determine what portion of the amount paid by Medicaid would have been paid by the third party. Evidence of third party liability must be documented by the quality control reviewer. This documentation requirement may involve a signed statement from a representative of an insurance carrier specifying that a third party was in fact liable for a beneficiary's medical expenses and the amount of that liability.

Another case would be where an absent parent is under court order to provide medical insurance benefits for the specified dependents. The quality

control reviewer may be able to verify with the absent parent's employer that the beneficiary in the case under review was covered under the employer's group policy. In this case, a signed statement identifying the persons covered, the specific months that services were covered and the maximum dollar amount available would be required. This statement would be necessary in cases where the employer acts as the insurance carrier.

Let me familiarize you with the turnaround document we use to communicate with a health insurance company verifying the exact liability. In the cover letter we send to the insurance company, we merely state that we are completing a quality control review and are enclosing a request for information summary worksheet. We indicate to them that we're enclosing hard copies of the invoices. We have a cover letter for health insurance companies, one for worker's compensation carriers and one, which is slightly different, for casualty companies.

This is the form that goes with that letter to the health insurance carrier. The form contains all of the data elements that are necessary. We have had no insurance company writing back to us that they can't identify the policy or the insured. This is a turnaround form in which we fill in this side and the top and they fill in the other side. We give them the policy holder's name and the employer's name. You will recall this information came off the field auditor's form that I showed you earlier. The group, control, or policy number, the contract number, the service code and the patient's name with the relationship of the patient to the policy holder are all on the form. If there is another group health insurance carrier, we provide this information in the coordination of benefits section. That information is necessary because they really can't determine their liability if there is another carrier out there. They have to coordinate benefits with the other carrier to determine their liability. Also, they want to know whether or not this is the result of an accident. If it is an auto accident or a worker's compensation accident, the health insurance carrier is interested because there may be a coordination of benefits between the health insurance company and the auto insurance company. You must let them know if there has been an accident. If it's a worker's compensation case, they definitely want to know because they have a right to seek reimbursement themselves from the worker's compensation carrier.

The claim reference number is the number contained in the right hand corner of our invoice. The invoices are going to be attached to that. You give them the provider type, the amount billed by the provider and the amount paid by Medicaid. Then, they indicate to us the benefit amount payable for each one of these items. If they don't cover it or if they have already paid it, they have the column "Reason for Rejection". They use one of these codes: "individual not covered, benefits exhausted, services not covered, the deductible amount not met, policy terminated, duplicate charge."

If they have made a payment from another source, then they indicate the date that they made that payment and to whom it was paid. We ask them for the processor's name and telephone number in case we have a question. On occasion there is a question and you have to call back and get it straightened out. We attach the medical invoices to this. What we are finding in a lot of instances is that the insurance company comes back to us and says, "Yes, we cover this service." Let's say it is a $15 service. The amount that Medicaid

paid is $15. They will put down benefit amount payable $15, but then they will put it in here under rejection code number four which is "Deductible Not Met." The problem is this: if we went to that insurance carrier before the third party liability unit went to that insurance carrier, you would have a $15 charge for this sample month, the $15 would meet the deductible and there would be no error on the part of the third party unit because in fact there is no third party resource for that specific $15. However, if you had sent claims in for the calendar year preceding this sample month, you would have exhausted the deductible and this $15 which is not in error today would in fact really be an error. We are doing something a little extra. Wherever we get a deductible amount, that deductible amount is netted back to the insurance company. We then get a history file for the calendar year on the recipient and send it to the insurance carrier a second time. Of course, we are not charging the State with an error because that doesn't fall within the Federal guidelines. However, we can suggest corrective action to the State and we can assist them. The purpose of this is not to try to catch them making mistakes, but to give them help. This type of situation occurs frequently.

That was error element number one. Error element number two is "Medicaid payment for services." The second condition that must be met in a third party liability error situation is the occurrence of a loss to the Medicaid program. That is, Medicaid must have paid for services covered by a third party. Thus, for sample cases where TPL is present, but no services were received during the review month, no errors can be present.

Error element number three is "Evidence of State action to recover." Because Medicaid agencies are required by law to maintain good provider relations and to pay claims within reasonable time periods, it will not always be possible for the agency to delay payment of a claim until third party liability issues are resolved. The third condition of the TPL error situation recognizes this fact in that no TPL error can occur until 30 days after the end of the month in which the claim was paid. Incidentally, if you looked at that draft regulation, you will note that the new third party liability regulation requires this in the situation where the State uses a post billing process. That is, they pay the provider and then go after the insurance carrier. Within 45 days they must seek reimbursement from a third party. This is in fact inconsistent with the quality control regulations. Therefore, the quality control regulations will have to be revised accordingly to be compatible with the third party liability regulations. Right now, there is no time frame requirement in the third party regulation, but reasonable measures must be taken. The new regulation will add that time frame and then the quality control standard will have to be revised.

Before a TPL error can exist, the quality control reviewer must establish that the Medicaid agency did not review or take action to recover third party funds within the specified time period. The quality control reviewer will generally accept the following as evidence that the State can recover from or can seek to recover third party funds. If the State does any one of these, then the State is free from error: (1) Correspondence from the State to a third party that notifies the carrier of the loss, notifies the third party of the loss, and requests information that is required for submitting a claim. (2) If there is correspondence from the State to a lawyer or other individual representing a beneficiary in a tort action, that indicates that the State

intends to seek recovery of third party losses for services during the review month. (3) If there is a record in the third party recovery unit file indicating that payment of the specific TPL covered claims under quality control review has been obtained from the third party, they have already made a collection, or the provider has made a collection; that is an indication in the record that there is no error. (4) If there is any type of record that might show that a claim has been filed with a third party to recover funds for the review month for services, this would indicate there is no error. (5) If there are other records in the State files indicating that appropriate State action has been taken to recover monies from a third party, then they won't be charged with an error.

If any of these five elements are contained in the recovery unit's file, then we can establish that there is no error, provided, of course, that the activity was performed within 30 days following the month in which Medicaid paid the claim. That is in the Federal definition.

Performance of the quality control review should provide many States with statistical evidence of the need for increased attention to their third party liability programs. It should provide evidence of the cost effectiveness of pursuing currently unexplored resources. The review should help to identify the problems encountered by recovery units and provide better direction and technical support in these areas. It should identify misspent dollars better than we have been able to in the past. We also believe that Medicaid quality control review should reduce Title XIX costs in health care expenditures. Are there any questions at all on anything I have said?

Comment: We have a system whereby during certification and recertification, the county worker asks about insurance, and also when a client goes for treatment, the provider of that service asks about insurance. We see a few cases in which the county office was told that the client has no insurance and the claim submitted by the provider indicates that they have inquired about insurance and received a negative answer. Yet, the client has insurance. Who has made an error in that case, or has anybody?

Answer: You have four places to which you can charge an error. You can charge the error to the county office for failure to report the third party resource to the third party unit. You can charge the recipient for failing to give that information, although it was asked for at the time of redetermination. Your example falls into this second category. It would be better to attribute the error to the recipient.

Question: What you are saying is that there is an error, but can you deal with it?

Answer: Right. We are finding approximately 18% to 20% of the errors are created in situations where the field auditor went out and found the resource directly from the recipient, even though the caseworker was not able to do it. Although the caseworker asked for the information, the recipient said "No." At least the caseworker indicated on the record that they had asked for the information.

Also, you can charge claims processing with an error if you have an edit in your system for this third party and the edits are turned off and you end up with errors as a result.

Fourth, you can charge the third party recovery unit for the error in cases where they have the information. They have it on their data base, but are not making use of it.

Question: What are the findings on the basis of your experience? Is it your impression that the third party is actually missing a substantial amount or are you coming up with a pretty good job? Are you far enough into it to know?

Answer: I can only give you specifics at this point. We are finding substantial errors. I sat down with my staff this week and started laying out a corrective action report which is due before the 31st of July. Now that we know what the mistakes are, we are proposing actions to correct those mistakes.

Question: They have come to me to find out how to investigate because they don't know that much about insurance. I'm the guy who investigates, but I'm curious about the experience of other States. Are they finding that the third party liability programs are generally seriously deficient?

Answer: I'll tell you what you are going to find. I don't know what the results are in D.C. or what you are getting back, but you will find whitewash. You are going to find a State finding no errors in their TPL unit when in fact there are errors, but they are saying no errors either because they don't know how to look for them, or they don't know TPL. Perhaps they don't have people experienced in that area, or they are finding errors and are overlooking them because they dread losing FFP. This attitude is ignorant because 50% of it is their own money. If there are in fact millions of dollars as everyone claims there is from third party, (there's no question in my mind that there are millions of dollars in any given State), then quality control could be very helpful to the State. Still, I think a big problem exists on both the Federal and on the State levels because quality control people do not have backgrounds in TPL and claims processing. I was fortunate in Michigan to have my TPL supervisor. I used to be the TPL manager in Michigan. I got people right out of that unit and the same with my claims processing unit. I have people from invoice processing in Medicaid. Therefore, I have people with backgrounds. That's the kind of people that quality control should be looking for.

Comment: I'm afraid that our unit consists of mostly amateurs.

Answer: I think that TPL is a good program but that people who are aware of its potential are not high enough on the ladder to really be influential. Many people in these sessions from State operations will tell you they can't convince their legislature. We were lucky in Michigan, our legislature backs the third party liability program. Still, you have internal problems and management problems. You may have your programming people, your computer people, in one bureau and your Medicaid in another bureau. Medicaid may not have their own programming staff and those programming people may have other priorities. One of the problems in Michigan is that they have other priorities from other areas. The third party is the least of those. So, Michigan is running into a problem with that.

Question: How about these so called State indemnity policies, our TPL guidelines say you don't have to collect them.

Answer: No, because it is not for medical care.

Question: Then an indemnity policy on which the State has not collected is not an error?

Answer: No, unless it spells out for medical care, hospitalization, medical bills, or what have you. The kind of policy you are talking about is one that will pay you X amount of dollars if you are sick for X amount of days.

Comment: This is what most of our SSI people have.

Answer: That's an eligibility problem. That's something that should be recorded by the eligibility staff.

Question: Other than the eligibility field review, do your auditors tie into any other State agency to determine third party liability? For example, child support, Division of Motor Vehicles, commercial carriers?

Answer: Yes, we have asked them if they can give us a copy of the divorce decree if it is a court order and the information is not filled in. If they give us a copy they get it from the IV-D agency or from the Michigan Court. Most of the medical support resources that come in have the court order attached to them. They get it from another agency. Police reports we are not really interested in, nor are we interested in the field auditor going out and getting them. If they give us the information we ask for, we will get the specifics on the accident from the insurance company. You can always get a copy of the police report if more information is needed.

Question: If the client indicates no other health insurance, at what point do you stop making determinations in the quality control area?

Answer: If the client indicates no other health insurance, then you take his or her word for it. However, you can ask about the divorce decree to find out if there is a court order concerning the provision of health insurance. If there is, then you find out where the person who is required to provide the health insurance is employed. If he/she is employed, he/she has health insurance. I don't care what kind of job you have in this country, there are very few occupations that don't provide health insurance coverage. That's a standard benefit. If you are a dishwasher in a restaurant, you are going to belong to some dishwashers' union that has health insurance.

Question: I just wanted to ask your opinion on Federal quality control. Medicare has a quality assurance system which is computerized. Do you think there would be a strong objection from the States if we made the same requirement of the States to go for a program of their own?

Answer: Medicaid or Medicare. I can understand his point of view. In Medicare there is a 100% Federal money in there, unlike Medicaid which involves 50% of the funds from the State. Therefore, you cannot impose a system on the State and demand that they do it.

Question: In other words, they are talking about a mandate from us to come up with a quality assurance system for Medicaid.

Answer: We have quality assurance programs for Medicaid. However, some of them are automated and some of them are manually operated. Your third party is part of it, but some of your systems are all independent and some are automated, are they not?

Question: Yes, but I think for the most part, all of them are going for automation. They want to be MMIS certified. Those States that are not MMIS certified are striving to become MMIS certified.

Question: Are there any States that are not trying for MMIS?

Answer: Yes, there are some which are not MMIS certified.

Question: Really, that's unusual because there is tremendous Federal matching -- 90% Federal matching!

Comment: In the way that you or the Feds operate with the States, it is not really a mandate. For example, the MMIS is an option. The only incentive that we give to the States is that we will give them Federal matching if they implement an MMIS, but you know the story. There are actually 53 different Medicaid programs. We do not place a mandate on a State to execute a job in a particular way as long as they meet the criteria. Quality control fits into this thing. We can't say that you must computerize quality control. The only thing we can say is that you have a quality control program that meets the criteria. Does that answer your question?

Question: In quality assurance, are you looking at the same items?

Answer: Yes. In quality assurance there is no difference. That form with one exception has been found to be inadequate for our purposes. Thus, we are not using that form. However, we are getting the information that is required to perform the quality assurance job.

Comment: I think what he was just saying is that quality assurance should be standardized. I think that is the word we are looking for throughout the States. I think that he was implying that if it is not, then there should be an attempt to do so. As far as I know, the Medicare quality control process is pretty much standardized. It's pretty much laid out in the Medicare quality control guidelines.

Answer: Yes, that is what I said in the beginning of my presentation. You are going to find that they are doing the same thing in all 50 States. Yes, it is definitely standardized. In fact, too much of it is very restrictive. I think it should be broadened a little more to allow the States more freedom, if it's really going to be effective.

Any other questions?

Thank you very much for your time.

BUDGETING FOR TPL

Fred Sapetti

Chief, Bureau of Claims Processing

Illinois Department of Public Aid

Stephen Harrison

Chief, Third Party Liability Unit

California Department of Health Services

Fred Sapetti:

What I am going to tell you about today is the budgeting process that we use in Illinois and the reasons why we went this route with budgeting. Hopefully, my comments will point out some of the pitfalls that should be avoided in the budgeting process.

First, we'll talk a little bit about our caseload size in Illinois. We have a little over 950,000 recipients of Medicaid in the State of Illinois. Our annual Medicaid expenditure in the State is in the neighborhood of $1.2 billion a year. We have a comprehensive program coverage in Illinois. There are very few medical services that are excluded or limited in the Illinois Medicaid program.

At this point we are basically in the process of implementing an MMIS, using a phased approach which will take about one year. I'll give you a little background on that. Three years ago we, the single State agency, implemented our drug program into the MMIS, which is approximately one half of our claims volume. Frankly, it was somewhat of a fiasco and cost us a lot of grief and heartbreak because we attempted to implement it with our own limited resources. Thereafter, a decision was made to contract the remaining portion of our system implementation to an outside contractor. We subsequently did that. Last year the contract was awarded for a phased approach for the remaining part of the claims system.

By "phased approach" I mean that we are bringing in various types at different times within the annual contract period. Just recently on May 1, we implemented hospitals, inpatient and outpatient clinics into the MMIS. On October 1, we are going to bring in all individual practitioners. At the end of the contract period, January 1, 1980, we will implement the remaining practitioner types, the major one being group care. There are other smaller areas such as home health, medical transportation and Medicare crossover that will also be implemented in our MMIS at that time.

With respect to the budget process for TPL, we took a phased budget approach over several fiscal years. First, for Fiscal Year 1978, we had included the salary of a manager in our Medicaid budget. We got the manager on board. For Fiscal Year 1979, because of our implementation approach with MMIS, we budgeted a staff based on our implementation efforts and our integration into the MMIS. Basically, we budgeted for a staff that would be instrumental in bringing up TPL in conjunction with MMIS, not a staff that would support an ongoing program. For Fiscal Year 1980, next fiscal year, we budgeted a full fledged staff based on an ongoing program. In our budget we did not allocate costs attributable to data processing, primarily because in our MMIS contract, a portion of those costs were included in the contract for programming and efforts involved in bringing up and implementing TPL. It was impossible to identify the costs attributable to our TPL system, primarily because of the way the RFP was written with respect to TPL. It was very general in stating what third party requirements would be for the State of Illinois.

With respect to budgeting for TPL, I think I'm just going to point out some of the things that you have to do. These comments are going to be tailored to the States that are just getting into it or have yet to get into it. I think there might be some worthwhile points here as to things you ought to, or maybe ought not to do, with respect to budgeting.

First of all, you have to determine what kind of program you are going to have. Is it going to be primarily geared to the cost avoidance approach? Is it going to be primarily a benefit recovery approach? It will not be clear cut one way or the other because you are going to have some combination of these two approaches. It can be swayed one way or the other. You can have a high degree of cost avoidance or you can have a high degree of cost benefit recovery.

One thing that we began with is researching other States' programs to see what they were doing. We visited several other States. We contacted them by phone and attempted to get information from them with respect to their TPL efforts and the manner in which they were approaching TPL. From that, it is important to determine what works best in your State. I would be the first one to support this statement mentioned earlier in this conference: Don't be afraid to go to other States. Don't be afraid to take what they have in place and tailor it, if necessary, to meet your needs. If you are new in it like we were, it's pretty hard to come up with something on your own. You're bound to get a lot of good ideas and a lot of good support from other States. Be ready to admit that you are willing to take other States' programs or parts of their programs and tailor them to come up with a comprehensive program of your own.

After that, we came up with an overall overview of how we wanted TPL to work in our State. We determined what we wanted to do with TPL, developing a comprehensive overview of the way we wanted it to work. Then, we went to our own agency administration for approval of this approach to a third party program. After getting this approval, we began looking for staff.

As a part of the staffing requirements for TPL in your budget, I think you have to look at three areas that you can base your staffing requirements on. You are going to have to base your staff requirements on the depth of effort that you are going into in TPL. For instance, in Illinois we have a IV-D program in place. We had a programming unit that was responsible for handling tort situations, personal injuries, or what have you. Basically, the decision was made that in our TPL efforts, we would concentrate highly on the health insurance area. Beyond that we wanted to be able to assist these existing areas by feeding them information gleaned from our trauma coding and from accident injury codes on the MMIS claim forms as they were processed from our claims processing system.

Another basis for staffing is the degree of automation that you have. If you are a highly manual operation and highly benefit recovery, you are going to have increased manual intervention in that operation. Therefore, you are going to need bodies to perform all the functions that are required by a high degree of benefit recovery.

When we determined the number of staff required for our implementation of the MMIS TPL phase-in effort, we broke our TPL functions down into several areas -- the local office operations area; the health insurance area; our

liaison with the tort and IV-D people; and, of course, data control and reporting. In our local office operations area, in other words our interaction with the field, we were fortunate enough to find people who had worked in the field. As a matter of fact, we hired a person who had been a local office superintendent and who was responsible for local office operations. I think you have to look at these kinds of things. You have to look at the different areas.

You have to determine what different types of expertise you need in the different areas. It's definitely an advantage to you if you can draw people who have this sort of background from within your own agency.

In order to come up with your budget you're going to have to justify the TPL program. Of course, the bottom line on program justification is dollar savings - how much money can you save or recover? I think it's highly important that in your budget you project a solid figure as to your cost benefit ratio. I also think it's very important that in determining what your cost benefit ratio might be, to make a great effort to include in your costs all supportive costs for TPL. We were unable to do this initially. In the furture we intend to. Initially, we were unable to determine what our data processing costs for TPL were. That's a significant portion of your TPL effort. You are going to have to attribute all costs of your TPL program in coming up with a realistic cost benefit ratio. If not, you are going to get hit with that. If you are using only your personnel costs, you are not costing out equipment, you are not costing out data processing, etc. Someone is going to hit you over the head with that.

Beyond that, along the lines of program justification, you've got your Federal mandates for TPL activities and your Medicaid quality control program. That's always a good justification in terms of loss of FFP. In our State we have to go through the agency budgeting process, then through the executive branch, through the bureau of the budget, and, of course, for final approval, it goes to the legislature. Most notably, you experience cuts all along the way, not only within your own agency, but within the executive branch. I think there's an unwritten rule in our State in the legislature that no matter what you ask for, you get cut 5% right off the bat. It's important that you point out that you can justify your budget to the Nth degree.

The bottom line is have your act together when it comes to budget time. Make sure you can answer those tough questions that you anticipate getting, particularly from outside your agency. The budget process in our State, as I indicated, comes under very close scrutiny from the executive branch, and beyond that, the legislature. We are called upon to testify and to answer those detailed questions. It's very important that you have your act together to justify your TPL budget, otherwise, it's very likely that you're going to get cut. Come up with a realistic budget showing that with any percentage cut, you are not going to be able to do what you want to do with that program. For example, for our Fiscal Year 1980 budget, we have eight staff on board now for TPL. That includes the manager and some clerical staff. We requested an additional 29 staff. The request got out of our agency intact. When it got to the executive branch they reasoned, since we are using a phased approach and would not have an ongoing, up and running TPL program until sometime in Fiscal Year 1980, they funded the entire staff for one half year. When the legislative branch got it they cut that budget

exactly in half. Consequently, I had 15 staff funded for one half year. Finally, it came back to us. We had three hours to write a position paper to attempt to get as many of those staff back that were cut initially. We scurried around and got the words down on paper, doing what we thought was a fairly good job for justifying our initial request. The last word I got, although our agency's budget has not been acted upon in the legislature, was that those positions were restored for our TPL efforts. I guess the bottom line here is when you go into a budget process know what you want, have the figures and have all the facts to justify whatever you are asking for. If you don't, you'll never make it.

Stephen Harrison:

I'm Steve Harrison. I'm Chief of the TPL Unit in California. I operate the post-payment recovery system for health insurance and casualty insurance in California. My organization also provides the accounts receivable monitoring for the TPL efforts in the recovery section of which I'm a part.

I don't want to go through and give a big speech on this handout. I just want to emphasize some things to give you a little background of what we went through in California. Six years ago post-payment TPL activities in California consisted of eight people. Right now we have 141. We are going to be getting an additional 23 resources this coming year. It's growing. The primary reason for its growth, in spite of Proposition 13, is that we are a revenue generating organization for the Medicaid program. I guess you are all aware of all the cutbacks in State government.

In the budgeting sense, or in acquiring resources, you have to sell your program. Budgeting is not an exercise that you go through to fill squares, at least not in the TPL business. Budgeting is an educational process. If your States are anything like California is today, even after six years in the business, most people, legislators included, don't know TPL from a hot brick. However, they are starting to get interested in TPL. The reason they are getting interested is because our budget packages that we submitted point out that TPL is not just a Federal mandate. TPL is a money maker. Politically, it makes them look good. You have to point that out to them. Our budget package is not much different from any of the reports we generate on activities. The wording is more or less the same. Every chance we get we try to educate people on TPL, selling it to them and letting them become aware of it. From a cost benefit point of view, the program results will sell themselves. The only reason the legislature or the department would turn down your budgeting situation or turn down your request is that you don't have sufficient justification data-wise to make them believe it.

The second is for some political reason. Recently, we went through bringing on a casualty function that we are taking over from the medical intermediary to operate ourselves. Then Proposition 13 hit the State. When we submitted our budget package we indicated that it would take 50 to 60 staff with heavy computer support in order to operate the system in California. This was cut back by the department to 35 staff. However, the State Department of Finance, another organization, and the HEW people in Region IX became interested in how we were doing in this. We were saying we needed 50-60 staff and were cut back to 35 because of Proposition 13. The bottom line is we are going to get 58 people, because the legislature wasn't really ready to take the heat involved in throwing this money away. Obviously, if you don't recover it now, you're not going to recover it five years from now.

In our department, which consists of approximately 4,000 people in the California Department of Health Services, we are one of three organizations that are getting additional staff resources this coming year. We are getting what we've asked for. Now it's up to us to come across with the money we said we are going to get. Again, successful budgeting for TPL is an educational process. It's outside of putting money in the bank. In a post-payment system budgeting is the most important thing a manager can do.

In the handout, I have put out a process consisting of several steps that I feel are important in getting started in budgeting for TPL. You can't produce a TPL budget for health insurance, casualty, or anything unless you know your State's medical assistance program. The first thing you have to do is become an expert on your State's program as well as your TPL program. An expert is a person who has accumulated data and has longevity in the program. To become an expert you accumulate data. You go around and ask people. For instance, you have to start off by knowing your State's medical assistance program by age category; how your eligibility process works; your redetermination process; what your State is paying in claims and to whom -- doctors, hospitals and such. It's important when you start to project TPL recovery.

A case in point is California's medically indigent population, which accounts for 10% of the State's Medicaid people. However, in the health insurance area, 25% of what I put in the bank comes from this 10%. You have to know that. If you have a high medically indigent, medically needy population, they are usually fairly well insured when it comes to health insurance. You have to know your State's medical assistance program.

You also have to know what other TPL efforts are going on in your State. In California six years ago there was a little bit of TPL here and a little bit there. Nobody knew what anybody else was doing -- big bureaucracy. Find out who's doing what so you can work together. Then, you have to get together with the insurance industry, especially if you are just starting out. Your insurance commissioner could be of help. A better source of help would be the HIAA who would be willing to help you and tell you about the industry. Just don't make any commitments to them and don't sell anything. They are a resource. Use them.

Find out what other States are doing. One of the reasons we had this conference was to develop contact with people in other States. Don't reinvent the wheel. Some of the best work we've done in California, we've done with scissors and tape. Benefit from our mistakes in putting a program together - we've made a lot of them. In my opinion there is no wrong way of approaching TPL. The worst thing in TPL that you could do is nothing. A big complex computer system will work. A manual system with two clerks will also work. There's such a wealth of resources out there to scoop up. Find out what other States are doing and try to benefit from their mistakes.

I agree that the primary, most important selling point in any TPL budgeting package, especially in a post-payment system, is your cost benefit ratio. That's what's going to sell it. If you spend a dollar to collect a dollar you have no reason to be in business. If you spend two dollars to collect a dollar you should be in jail. But, in TPL with just about any level of effort, you are going to have a positive cost benefit ratio.

The hardest thing to do in determining the cost benefit ratio is finding out what your costs are. It's easy to find out what the collections are. Costs are difficult. The costs are not just limited to staff, although the staff is probably the biggest portion of your cost. You have other costs. Our staff budget for health insurance is $1 million. However, in the health insurance and casualty system we spend $500,000 a year in computer services. We have a WATS line and do a lot of calling to insurance companies across the

nation. Our phone bills run between $50,000 and $70,000 a year. You have to know your costs to come up with a legitimate cost benefit ratio. One of the pits you could fall into is using a high cost benefit ratio that includes staff resources only against collections.

When you submit a budget and it hits the Department of Finance asking for more people, their several analysts over there are going to take you and nail you to the wall. They do that in California. You have to know what you're spending. Don't ask for it. Demand it. It took us a couple of years in California to really get our true cost picture under control.

Back to the cost benefit ratio. The number of staff you are going to need for TPL programs seems to be, nationwide, directly related to the size of your medical assistance program. In California we have one TPL person for every 36,000 recipients. In Washington, I think it's one for every 20,000. Anywhere in between will give you a good ball park estimate of what you should be shooting for. The actual number you need will depend on the degree of automation. If you are highly automated you probably will need less people. If it's a strictly manual business you're in, you'll probably need a larger proportion of staff to population.

It also depends on your skill of operation and how broad you are going after it. In some States they just go after the major insurance companies, the top 25. We don't do that in California. Because we are lucky enough to have a computer system, we go after any insurance entity, trust fund or what have you that has even one Medicaid individual on their files. I deal with approximately 1,900 claims paying agencies throughout the United States. Again, it depends on how big a chunk you are going after. It also depends on the depth of your efforts. For example, you may opt to go after major medicals. That's usually where the big bucks are. In California we go after major medical that will pay anything. If I didn't have a computer system, I would start off and go after major medical or just handle hospital claims. That's where your big bucks are, giving you a bigger return on your investment.

The types of staff you'll need are clerical, technical, analysts and managerial. The most important people you have would be what we classify in California as an analyst. These are what you call general governmental program analysts. They are not collectors. They are not clerks. It's a training ground for management. These people are not necessarily computer specialists. They are people that know how to plan, can ask questions, and write and speak very well. If you are fortunate enough to get analysts to work for you, they can help you collect and present data. It's always better to have an analyst working for you than to rely upon departmental management, services pools, or something like that.

Again, your clerical staff, whether you have an automated system or a manual system, historically, would be the largest percentage of your TPL staff. Again, they should have billing, case processing experience and accounts receivable types of experience.

Your technical staff in California are what we refer to as the hard nosed collectors. These are the technicians. These people go out and get the

bucks. They deal with negative situations with providers or insurance companies who owe money to the State. We have one 50 year old 5'2" grandmother who is known as Mad Dog Stinko. That's the type of individual you want. Very assertive. She's a sweet little old lady unless you owe her money. Then she could take the pennies off a dead man's eyes. I would hate to have her on my case. That's what you need. Assertive people who are not afraid to go out and do it. Our collectors in California think it is easier to apologize than to ask permission when you are going out. That's what you need here.

A lot of people seem to feel that insurance industry experience for managers and for staff is a vital necessity in running a health insurance or casualty insurance TPL program. No, it's not. I'm only talking to you from California's experience. What you need are people who are inquisitive and assertive. Don't rely on experience. One of the pitfalls in getting someone with experience is they may have blinders on. They may have been in that process so long that they have accepted it the way it is. They don't question why it is the way it is or suggest new ways of doing things. They may have lost their creativity. Get creative people.

Getting back to the State budgeting process. Everybody has a different budgeting process. On Page three of the handout, I've tried to put down eight categories or elements that should be in one form or another, included in any budget that you produce. The important thing about these elements is that producing a 20 or 30 page budget package with a lot of data may be a great thing. However, realistically, no department director or legislator is going to read the damn thing. You've got to make the stuff they're going to read short, clear, concise and right up front. All they're going to read are the first few pages. You take your elements here and shorten them. Put in your first few pages using these elements, the things you want these people to remember. The data and all the expensive narrative they are not going to remember even if they read it. Keep it in their minds. In the last page of the handout, I have put an example of what we put in our budget for California's health insurance program statement. The program statement is the number one element. Page three will show you how the program statement is broken down. That's what I want the department's directors, the Department of Finance, and the legislators to remember and stick in their minds.

Now on to system modifications. If you have a system or if you are considering automating a system, the Federal government can spring some of your data processing costs. They will fund, if approved, 90% of the developmental and 75% of the ongoing computer costs of your system -- another reason to get a handle on costs. We were just putting together a heavily computerized based system and we got a letter from Region IX saying that they are going to fund us at the 90/75% level. Again, the department and your legislature will be happy with this. I love having them pick up 90% of $200,000 in developmental costs. That can be done. I don't feel that this is as difficult as what they may have said yesterday with all kinds of allocations, costs and such. We gave them a copy of the feasibility study and had the Region come out and talk to us about the system. Don't be afraid of that. Again, ask for it if you are going to automate. They'll spring for it.

I was asked to talk about supplemental budget. You've got your initial staff and are starting a program. Just when you get into it you suddenly

discover the workload you have is incredible. You wonder what you should do. Ask for more resources? You can wait and go through the regular budgeting process or you can utilize what we call Section 28 of the Budget Act, which is the supplemental type of budget. My suggestion to you is don't utilize the latter. It would be better for you to put up with the excessive workload than to constantly go crying wolf, wanting more and more staff. Again, it's primarily important if you are just starting out. My opinion is that in the first year of operation, developing credibility is far more important than the amount of money you put in the bank. You have to get confidence, credibility and respect for what you do. My suggestion would be -- don't put in for a supplemental budget.

Let's say you have an excessive workload. There's 30 lbs. that you can't get in your 5 lb. bag. You should be happy that's occurring. What that's doing for you is developing concrete real data, not estimates or projections. You can say, if you don't believe my estimates look at the work laying here. When you go in for your next regular budget cycle you have a strong case, they can't really turn that down. Well, they can, anything's possible.

Again, you get something going and four or five months later you go in again begging for more. Under a supplemental budget in California, what you usually get are temporary staff. You don't want temporary staff. You want permanent people. Even if you get temporary staff for this workload, when you come to your regular budget cycle, you want permanent people. When you go in again they will look at your history and wonder what you're doing and what you are asking for. Do they know what they are doing? They asked and said they need this many people to do this, and three months later they are coming in and saying we were wrong, we need this many. What they'll do is come back to you and say, "You're not getting a damn thing until you get your act together and give us some realistic figures or projections of what you need." You have lost your credibility. You don't want that. If I was to go through it again, I'd eat the excess workload. I'd just let it pile up. I'd study it, get it lined up and then really lay a heavy trip on them for budgeting.

In conclusion, I'd like to say that TPL has been left out in the cold for many years. I've only been in the business for five years, by the way. I'm not an old timer. Even in the five years I've been into it, the gravy train, Federal government and State government, has been growing all the time. Lots of money and no problems, but over the last couple years, it appears that the gravy train is pulling out. The Feds, I've noticed, are getting terribly interested in TPL now because it can save tax money. The States are terribly interested in it. Everyone's budgeting requirements are quite extensive and they're getting more so, in order to justify any additional resources. For a TPL program this is just the type of environment you want. Because you make money or you offset money. You're saving them money or you're putting money in the bank. That's the type of fiscal climate that's great. That's the best thing that's happened to TPL since it began.

I'd like to answer questions.

Question: Did you out of necessity start small with something provable or demonstrable, or when you first started out, try to go as big as you possibly thought you could?

Answer: At the time we started, information about TPL was very difficult to come by. There was no help from the Feds. We were the only game in town. There was no other organization we could go to. We made estimates and we looked at them and we went -- Nah. I can't really present a true picture of what is out there. They would probably take you away in a truck and put you in a hole. We had to tone it down quite a bit to get to where it was still a big giant picture, but it was more believable. We did start small. In fact, the program never really got started at least in the health insurance area. We started with a manual system and had 18 clerks manually processing some claims and that sort of thing. We were asking the medical intermediary to send us the claims that had indications of health insurance involvement on the Medi-Cal card. We ended up with 900 crates of claims. What happened was the press found out about it. There was a picture of Jerry standing there by these several tons of claims with the story the State was losing millions because they didn't have the resources to go after it. Within a year after that article came out we had an automated system and 55 people. They had interest again in the program.

That's when it took off. Again, in getting started in the program, one of the best friends you could have would be an HEW auditor. If they haven't been out to audit your State's TPL efforts, I'd strongly suggest that you ask them to come out and audit you. Come out and look at the TPL efforts in our State, write a bid report and send copies over to the directors or to the legislators. We need your assistance. It's great. I've gotten a lot of mileage out of those reports. They may look beyond their initially making you look bad. They come in and say your TPL unit is not doing this, it's not doing that and it's not doing the other. That may make you feel bad. Then, when you are asked why you aren't doing that, when you talk to the director you can say that you don't have the resources to do that. I don't have the computer money. I don't have the staff. You give me the resources, then we can do that. Those audits are a big help.

Question: Which is the best way to get yourself a good track record, to go cost avoidance, or pay and chase?

Answer: You've got to do both. California has been accused of being a pay and chase State or post-payment recovery State. This is not true. Last year I collected $7.5 million from health insurance companies on post-payment recovery efforts. 80% of California's health insurance business is cost avoidance. Also, I'd like to say that these providers are collecting and reporting this $44 million and they are not getting any input from me as to whom the insurance is going, or anything like that. Personally, I'm somewhat opposed to assisting providers in making money. They don't need my help to do that. I don't provide them with any information. They are collecting and reporting $44 million a year. We don't know how much they're collecting and not reporting, and whether or not they are submitting a claim to the program.

Another thing about a post-payment system is that it is a very good complement to your cost avoidance system. If you've got an entirely post-payment or an entirely cost avoidance, that's putting your money on number six on the roulette table. You may win big, but you could lose big. You probably will lose.

We bill our insurance company. Then, the insurance company sends the bill back letting us know the service is covered. However, they have already

paid the provider or beneficiary for the service. Many of the insurance carriers we are dealing with will send us a copy of the check they sent to them. We come to find out that through some administrative error, the provider didn't report that on his claim. At that point Mad Dog Stinko talks to the provider. She says, "Okay, sucker, you can write us a check for the money or we are going to tell the medical intermediary to withhold your claims until we get our money back." We got $800,000 last year in that business from providers alone. We call it our provider education kind of coverage. You would be appalled by the number of billing clerks and their turnover rate in California's doctors' offices.

Question: Do you run into legal problems when you pend payments?

Answer: We don't pend them. We just don't pay them until we get our money back. We put them on withhold until we recover what they owe us. They don't have a legal leg to stand on, because we've got them cold. The insurance carrier is giving us the information.

Comment: I think he's offsetting. What you are doing is offsetting against claims going out. You're taking a credit process more or less.

Answer: Right, we are just saying if they owe us $1,000 we aren't going to pay their next $1,000 worth of claims. We have that right because they've already got the money. We give them the option to pay us if they don't want an interruption in payment of their claims. Again, they're in the business to make money. They're not in the business to help mankind or anything else. They are profit makers just like anyone else. They should be treated like businesspersons.

Question: If you would address the questions of staff in either State you mentioned, what type of entrance person are you looking for to actually handle the workloads?

Answer: Let me give you a case in point. The best analyst I have who has become a real expert in our system and who is really a whiz in dealing with insurance companies is a former right of way agent from the Department of Transportation in California. Some of our better collectors who are in the collection field are former clerical personnel with accounting backgrounds. Again, education is cheap. You can shake a tree and get a lot of educated people. You can shake a tree and get a lot of people and a lot of experience. I rate desire, enthusiasm and assertiveness higher than I rate education or background. You get people like that and you can teach anybody this business. It isn't all that difficult. The right kind of people bring a new perspective and creativity which is what you are looking for, especially if you are starting out. Anything you do, try something out. Maybe you will hit on something that I'll hear about and stop by and wear our your Xerox machine in hauling it off. That's another reason I like to come to these conferences and talk to State people, because I'll steal any good ideas or anything I think will work in California. That's what you have to do, too.

Question: How do you recoup the dollars from the recipient when they have paid for something?

Answer: I run what we call in TPL the health insurance and casualty insurance. Those are the two major things we have going in post-payment.

The other half is what we call compliance. This is probate, paternity, overpayment, and a dozen other small programs. You get into operations and responsibility on the part of the worker.

Comment: In Illinois, we are governed by a civil service. At our clerical staff level, we anticipate and we want to get claims examiners from insurance companies. If we have clericals working in accounts receivable or accounting, we like to draw from people within our own agency who have been working in a fiscal area. The educational requirements are not as important to us as their background and experience. That's the kind of thing that you have to look at. You can get clerical staff, but if you can get clerical staff with claims examining background, that's a plus. We have some of our people at a level higher than clerical.

Comment: I'd like to build on that. In California, in TPL, we are fortunate enough to be of such a size that we can bring people up through the ranks. Our theory is that a person who has been with us one day is much more valuable than a new person. If I can take clericals and work them into collections or technical aspects, I do it. In starting out our casualty program we had 18 collectors; 14 of them were trainees.

Question: I didn't hear any mention of a legal staff. Would that be desirable? For example, do we have to go through the legislature to get some things done?

Answer: We have a legal department within our agency. We have one of those attorneys from whom we draw any kind of legal advice that is required in this area. I don't see a real need to have a full time attorney on board in our TPL area as long as I've got access to that kind of expertise.

Comment: I agree. We don't have one working in our organization. However, in our department we keep a couple of legal counsels who work at different organizations. We tap them and contract with the State's Attorney General for legal support.

Comment: Another pool from which you can draw for this kind of support is people attending law school. This is a law type work that might interest them as trainees. We've had some quasi-attorneys through law students. Very helpful.

Comment: We had ours cut from legal assistants to paralegal. That is still up in the air. We wanted them for a short time to help in drafting legislation. Although we have legal staff available within the department, they have other fish to fry.

Comment: We had an analyst who became a member of the California Bar Association when he was an analyst with us. Now he is working in our Legal Counsel's office in the department. That's one big advantage. He knows our program. I don't know if it is beneficial to have a lawyer. My personal opinion is that it is usually a waste of money. I'd rather take the money I'd pay a lawyer and buy clerks.

(California's TPL data summary follows this text.)

CALIFORNIA TPL DATA

The following summarizes the types of data found to be successful in California for securing budget resources.

A. Medical Assistance Program Recipient Population

Aid Category	Recipients	Percent Identified with some Insurance
0 Special	11,900	4.0
1 Aged	396,700	2.8
2 Blind	13,200	0.9
3 AFDC	1,447,700	5.3
4 BHI	28,600	6.7
6 Disabled	389,500	0.9
8 MI/MNO	290,000	7.3
TOTAL	2,577,600	4.5%*

B. Medical Assistance Program Expenditures - Monthly**

Service Category	Dollars (Millions)	Percent
Hospitals	84.4	40
Nursing Homes	47.9	23
Physicians	34.0	16
Drugs	11.3	5
Dental	10.0	5
Other	21.7	10
TOTAL	$211.2	100%

* A pilot study conducted during 1977 indicates this figure should be 8.3%

** Excludes HMO, PHP data.

C. Post-Payment Automated Health Insurance Collections through June 30, 1978

Aid Category	Collections: Dollars	Collections: Percent	Percent of Recipient Population
0 Special	40,000	0.3	0.4
1 Aged	1,751,000	14.2	14.7
2 Blind	55,000	0.4	0.5
3 AFDC	4,459,000	36.2	53.5
4 BHI	81,000	0.7	1.1
6 Disabled	2,769,000	22.5	14.4
8 MI/MNO	3,177,000	25.8	10.7
TOTAL	$12,332,000	100%	100%

D. Prepayment Offsets for TPL from State Paid Claims Report for Calendar 1978*

Activity	Dollars (Millions)	Claims (Thousands)
Provider Billed	3,879	69,694
Program Payable	2,781	69,694
Health Insurance Deduction	44	54
Patient Liability	8	91
Medicare Deduction	826	5,776
NET PAID	$1,903	69,694

* Excludes some HMO, PHP expenditure data.

E. Benefit to Cost Ratios

	Health Insurance (Actual FY 77/78)	Casualty Insurance (Projected FY 79/80)	Total
Gross Collections	$9,865,000	$6,000,000	$15,865,000
Personnel Services	747,000	549,000	1,296,000
Administration	227,000	146,000	373,000
Computer Services	281,000	218,000	499,000
TOTAL COSTS	$1,255,000	$ 913,000	$ 2,168,000
Net Collections	$8,610,000	$5,087,000	$13,697,000
Benefit/Cost	8/1	7/1	7/1

F. Staff Requirements for Health and Casualty

1. Direct staff of TPL Unit

2	Managers	2%)	- 7%
4	Analysts	4%)	
18	Technical	20%)	- 20%
15	Accounting Clerical	17%)	
50	General Clerical	56%)	- 73%
89	TOTAL	100%	100%

2. Ancillary staff of Department

3 Data Processing Analysts
2 Key Entry Clerks
2 Account Clerks - Cashier
1 Personnel Technician
1 Business Services Technician

9 TOTAL

3. Legal staff - part time only

4 Department Attorneys
8-10 Attorney General Deputies
6 Legal Clerks

G. Health Insurance Program Statement

California's TPL program for post-payment recovery of health insurance is defined as follows:

1. Purpose: To lessen the burden of the Medi-Cal Program on the taxpayers of the State.

2. Objective: To maximize annual recoveries of monies owed the Medi-Cal Program by private health insurance carriers and other liable third party insurers.

3. Measurement: The degree of objective achievement is measured by the sum of monies recovered minus the costs of operation and compared with previous periods.

4. Philosophy: The managerial philosophy of the TPL Unit is that of a profit making service corporation with State taxpayers substituted for stockholders.

5. Methodology: The method used to achieve the objective consists of operating a data processing based system at the most efficient and effective level obtainable with the resources provided by the State.

6. Description: The Automated Health Insurance Collection System is designed for post-payment recoveries of monies owed the Medi-Cal Program from private health insurance carriers. It consists of a budgeted staff of 53 supported by approximately 100 sequential computer processes. The system is considered to be of moderate size and complexity. It is structured to:

   a) Accumulate information relative to Medi-Cal beneficiaries with private health insurance coverage;

   b) Generate to insurance carriers bills containing sufficient information relative to their insureds to allow them to process and reimburse the Medi-Cal Program;

   c) Provide accountability and control of the entitled reimbursements; and

   d) Encourage providers to bill carriers directly in lieu of billing Medicaid.

PROVIDER RELATIONSHIP
AND EDUCATION

IV-D - ABSENT PARENT

Russ Ward

Supervisor, Third Party Liability

Washington Department of Social and Health Services

We will now discuss how you will relate to the IV-D program. I think you are aware that we became involved with the issue of the IV-D agency taking the position that it was a separate and distinct agency and as thus, had nothing to do with parts of the other program. They have one prime responsibility. That responsibility is related to the absent parent, whether you are dealing with the non-assistance program or the assistance program. Then 95-142 came along and changed the entire situation. We ended up finding that we really were blood brothers after all. You could talk in terms of medical costs. We began talking in terms of what we were going to do in relation to contracting and who was going to contract with whom. Fortunately, 95-142 indicated that you should, wherever possible, avoid or eliminate the duplication of effort which was an intelligent idea; much better anyway than having so many people reviewing the same document. So we did that. But then the question came up of determining what the absent parent had in the form of resources.

Three years ago, in Chicago, I made the statement that potentially every child has a father and potentially every father has work. Furthermore, potentially in this day and age, every father that works has possible fringe benefits or something that spins off as potential insurance. Therefore, we should look for that as a resource in the Medicaid program. How much is in there, I still haven't determined after three years, even though I've worked in the IV-D agency. I'm convinced that there are resources there and that's why I maintain my physical location within the IV-D agency.

In 95-142, you discover that there are three areas of interest relating to the insurance from that absent parent. First, you are going to utilize all of the insurance that parent already has. We are going to identify that. Second, you are going to make available insurance that he/she can pay a small sum of money that will not exceed 10% of the support payment. I say let's be realistic. I know what it costs to buy health insurance. We are fortunate in our State in that the State picks up the total cost as far as insurance is concerned, but in one way or another they always remind you that this is a "fringe benefit." They want you to understand how much a month that fringe benefit is so you won't complain about your salary structure, that you're underpaid, etc. They keep reminding you that this figure keeps going up. The end result is that I have a general understanding of what it costs to buy insurance. The third aspect of 95-142 deals with the areas where we would say to the absent parent, we want you to buy insurance in order to cover these kids. Again, you reach a point where you say that it cannot exceed 10% of what the support payment is.

Let's go back. Suppose you are talking about $75 as a support payment. Tell me, where are you going to buy insurance for $7.50 that is worth anything? I can name many insurance companies that write that kind of stuff, but in dealing with it I have always said that the insurance commission ought to run them out of business, as far as our State is concerned, because the limitations on it are ridiculous.

Currently, I think we need to make sure that first we are going to go out and play the game wide open to utilize what is available from that absent parent at absolutely no cost. This should be our interest when we get talking about the interrelationship between the Title XIX people and the IV-D agency. How in the world can I identify what is readily available? This has been my procedure as far as my own State is concerned. I do every-

thing I possibly can to make sure my IV-D agency is identifying everything that is available at no cost whatsoever to that absent parent.

I have no intention of being an absent parent. My kids are grown up. However, I do have some empathy for an absent parent in this day and age with the high cost of living. I feel that it is our responsibility to determine what is available at no cost to that absent parent. If you have a sophisticated recovery program and you wish to add something to it, you should. My guess is that you haven't solved all the other problems, but solve some of those and make these work for you so that you can determine what that absent parent now has that can be utilized. For three years I have maintained the belief that there are benefits available through the absent parent. How much insurance and how many benefits those absent parents have is uncertain. In the State of Washington, we are doing our IV-D program on a computerized basis. I've been fortunate to be in a IV-D agency because of all the elements that were going into this stuff. I ended up dealing with the people who had been establishing all of the data elements that go into the IV-D program. As a result, what I'm interested in learning is what absent parents have by way of insurance. Here again we are talking about tracking systems, because we live in a highly mobile society. If you have a person who is a union member, you discover that as he/she changes from job to job, some of the coverage becomes different. I need to be able to track this person's employment history so that I can then say this is the latest data we have on him or her. Now let me say this. You're not going to convince that IV-D worker, who is like an intake worker, or a social worker to do all of this because they're already overworked and underpaid. I've been told that in no uncertain terms by our field office staff. We have what we call the field office staff and we also have the local office staff. The field office staff deals with our IV-D people. Our local office staff deals with the social work aspect of it. When I talk about the field office staff, I'm talking about those people who deal with the IV-D people. When I talk about the local office staff, I'm referring to the social work staff.

Immediately you find everyone defensive about their own particular field. The people within our office tell me that our field office staff is now already overworked. I've discovered that our IV-D people are more than willing to trade information with you and do things as long as you do not impose an undue hardship on them. What happens is that these guys become very interested in making this computer program work to their advantage. I said to our computer man, who has studied all the programs, "I want you to put into this thing, all in one shot, insurance information." This is what we are doing. As of July 1, we will have preliminary material in our computer system in the IV-D program so that I will be able to sit at the CRT and figure it out: Where does this man work? What is his union affiliation? I would also be able to determine what the insurance information is.

Question: Do you make collections out of your State?

Answer: No. Right now we are working strictly within the State. We may expand that situation later.

Question: Is there an insurance file on the individual father or do you have an insurance file in general?

Answer: That insurance information will be strictly on the father as the absent parent.

Question: Is it his specifically?

Answer: Yes. It is his insurance specifically.

Question: How do you tie Joe the father with Mary Jones and the kids?

Answer: It's part of the IV-D file in which it is cross-referenced in our system to the point where we know who the absent parent is and how this relates to the recipient. It also relates to the children who are covered. Identification is something we have built into the system.

Comment: The State has obviously decided to go for the option in the State plan. I'd like to hear from a State which is not a part of IV-D, but a separate agency. We're having problems with our IV-D people in the regional office in that their IV-D is not crossed over with information regarding the child support or court orders.

Comment: There have been a lot of problems between Medicaid and the IV-D. What we did was establish forms for the third party unit and IV-D people to exchange information with, because IV-D told us that many times they would arrive in court and not have any insurance information. What they would do when a case came in would be to request information from the third party person. In return they would tell the third party person what had been awarded in that court. Through very specific resource files, they were also able to tell the third party person who in turn was able to tell the IV-D person what was available and how much it was going to cost.

Comment: In North Carolina, our IV-D unit is with the Division of Social Services. We are also in the Division of Medical Systems. We have an interagency agreement with social services for eligibility intake and things like that, but we have opted at this point for IV-D and us not to get involved with the agreements they're talking about in TPL, Public Law 95-142. Still, we have very good relationships with the IV-D program in that they provide the intake worker with information that they find pertinent to the absent parent relative to health insurance. However, we don't have an agreement as such, but we do get good crossovers.

Question: Are any of you experiencing the interplay between the IV-D people and the local office people, meaning your intake worker, and the social worker aspect of this issue? Are those people communicating in your State?

Answer: In our State, it doesn't matter. It is not a separate application process. All recipients go into intake processing. All recipients are redetermined periodically, every two months or six months, depending on the category of assistance. It's not relevant whether the insurance is through IV-D from my perspective or through the recipient's employment. They can use the data collection document or insurance transmittal document to collect all insurance information at the local office level by the caseworker staff and the intake staff. You'll know our IV-D form is set up in a manner where the grantee's name and the insurance holder's name is on the form. Therefore, if you have a grantee's name and the insurance holder's name, there's a good

chance you have a IV-D insurance resource. We go into our files and check. Then, we can see if the insurance holder shows up. If he/she doesn't, they're out of the household definition and probably a IV-D.

Question: What are you doing in the area of identification?

Answer: I've always assumed that the IV-D people and the local office people make a referral to the IV-D people. I assumed that they get some feedback on the thing. I discovered that that's not necessarily so. One of the other things I discovered is that the mother that gets mad and gets after the other guy because of what he's done to her, does not tell the local office anything about him. I've been on the phone with some of these mothers and she says I could care less about what he's got. When you talk to them about insurance and what the father does, they don't care. You try to sit down and reason with them, but it doesn't work. The same thing holds true with the absent parent who has just married and goes after the woman for what she's done to him. She has walked off and now he pays support. The hotter you get these people, the more they share the information. Incidentally, in our State we're going to take the information and create a file for the IV-D system. We're going to generate it from the local office structure and then we're going to create strictly an insurance file of our own. Then we'll be able to run all of the claims that come in against the eligibility file. Then the yes/no indicators will determine our course of action. If the "yes" comes up, we will pass this thing by the insurance file to determine if there's insurance or not. We're going to gather the information from any place we can.

Question: Getting the information regarding policy insurance is not the problem. The biggest dilemma we have is that the angry father won't sign a claim, or the insurance says that it's paid to the policyholder. The check goes to him and he takes off. Our IV-D tell us that under normal support awards, we have a minimum to go after, so they won't go after these nickel and dime claims, they don't bother, they don't have the time. How can we get around that?

Answer: I haven't got an answer. We run into the same kinds of problems. We know the insurance is there, but the insurance company may not want to deal with us: we may have to get some sign off from the father, which he may not give us.

Question: Is it possible to get it as part of the court order, get your IV-D people to include XIX in as if he will provide the insurance?

Answer: Part of my courting situation, even with our own IV-D people, is to trade services. The IV-D people get involved with paternity claims.

Question: Do you know who provides them with all the data?

Answer: Yes. We've generated a form which we send out. In our State we deal with county prosecuting attorneys. We have one county in particular where it is a routine procedure when they go into court to impose support on the absent parent. It is a procedure where they will make available the insurance and this fellow must provide, or at least make available the insur-

ance that he has, at no cost to him. However, do not pressure the parent too much. Identify, does he have insurance? Then, tell the prosecuting attorney you want this taken care of. And the judge is going to tell him, you will make that insurance available. At least I've got my foot on the guy's neck then. Whether I can squeeze the blood out of him or not, is something else. You exert pressure to get these people to make it a part of the court order, but you're not going to win them all.

Question: It just means that IV-D says to you, you have this report here, and you want me to go after an $8 doctor bill? The man refuses to sign.

Answer: I don't have an answer.

Comment: We're trying to negotiate with the IV-D people in Maryland that we will accumulate medical bills so we're not submitting them each $8 bill. We'll submit to them on a six month basis, total payments for that child from the previous six months. This is a significant amount of money they are going after.

Question: Are you talking about cost avoidance?

Answer: What we're trying to do is have medical support included in the general support order that goes to the attorney's office. Then work out with IV-D as part of the case, once you get the support order, you have a hold on the absent parent that it is in his/her best interest to get some form of coverage. It is better than paying the bills out of pocket. At that point, IV-D will notify us of the insurance information, and then we will consider that as a normal insurance claim. Therefore, on an individual basis we can submit individual insurance forms. In those cases where the absent parent doesn't have insurance, we'll let the claims accumulate, and give those claims to IV-D, they will collect it as part of their monthly child support fund.

Question: How do you operate in the State of Washington between Medicaid and IV-D? You're within the IV-D unit, so how do you operate that? Do your IV-D people keep an accurate account of their time spent in getting this information for you for the FFP participation?

Answer: This is the reason why in North Carolina we haven't reached an agreement with IV-D because of the difference in the FFP and the accountability of time that you would spend.

Comment: Yes, this is a problem. We're still in the courting stage.

Comment: In discussion with IV-D too, they comment that a basic reason why we cannot get cooperation is the difference in FFP. In XIX, you are limited to that which is the State share.

Comment: Nobody seems to understand that half of that money, whatever your FFP share is, is State funds. It is not all Federal money. You're getting 50% FFP for your administrative costs from the Federal, then you're recovering in addition, the monies you would have laid out, and totally lost. So if you start working it out, you're approaching your recoveries, administrative charges, it's relatively high.

Comment: One of the things we have attempted, in answer to your question, is a kind of courting session with insurance companies. One ends up accumulating a conglomeration of these things. Is there some way you could make this payment to someone else other than the insured? We've been fairly successful in doing this with some people. I think I have three different insurance companies that are very heavily involved in fringe benefits as far as the labor movement is concerned. They would sooner pay us. We've gotten to the fact where they've sort of forgotten that we are cost avoidance in some of these things and we've paid some of the things.

Question: How does this fit in with the provider since we don't pay the provider the full amount that he/she might have gotten?

Answer: Just go to the providers and tell them the situation -- either you take what we're going to pay you, or you end up with nothing. Another thing to do, which we don't have the time to do, is try to act as a family counselor when you start communicating with the absent parent. We need to keep our lines of communication in order. I have said to our IV-D people that I don't want to contact that absent parent because all of a sudden he/she gets hold of the field office person and says who in the world is this guy Ward who called me from Olympia? I thought you were the person I was relating to. This is a trade off type thing with your field office staff. We don't want to do it, so you get the information for us. We are the ones in third party that are going to have to do the maneuvering. Nobody else is going to take care of our needs. I don't care whether you're talking about the people, the social workers or the IV-D people. We're the ones who are going to be responsible for initiating the activity. So don't sit around thinking that when somebody opens Pandora's box - out comes the whole wonderful thing that blossoms out in a flower garden. It won't work. If you're going to get information, you're going to have to work with the IV-D people in order to encourage them to include this as part of court orders. You're going to have to work with the IV-D people in order to get them to work with the absent parent. You will have to work with the local office people to see what kind of information you can obtain from them. We have the responsibility to take care of our particular area of need. Nobody's going to do it for you. Learn to be a horse trader. You are responsible for building a reputation for yourself in the third party operation. How are you going to do it?

Michigan has a good system. They contract the stuff out as far as the IV-D is concerned. They contract it out for their Friends of Court. They've gone out of their way to make this thing work for them.

I think the number one thing we need to do is to make sure that we are doing this as simply as possible for the absent parent. I would have some real reservations, if I was going to be in touch with an absent parent. Periodically, they call you up and want to know why we are involved with paying medical bills for their kids. I've got insurance, what have you? I'm taking care of my own kids, what are you doing trying to pay medical bills? Again, I'm interested in 1) appealing to their responsibility; and 2) utilizing those things that do not cost them anything. I have yet to say to one of our field office personnel, tell that prosecuting attorney that this guy is going to have to support his kids medically. 95-142 does indicate that no medical costs are part of a support. Our present TPL unit is inhouse with the IV-D unit. We are considering in the State Medicaid agency bringing it back over to the Medicaid agency, so we have a little more control there.

Question: Do you recommend that we stay with the IV-D agency because of the access to the information at the expense of losing that control with the Medicaid agency?

Answer: From my experience, I don't feel that I've lost any control as far as the Medicaid agency is concerned. I live in close contact with them. Beginning July 1, I'll have two CRTs in my office. One will access the IV-D system, the other will access the Medicaid system. So we have an inhouse system that will take care of the IV-D program plus all of the eligibility stuff. Then we'll end up where we have a separate data system for the medical. I will have access to both of these systems. You have to be related to the Title XIX people. I have been fighting for the last two to three years to stay within the IV-D agency, because this is an area where we end up unsure of how much money is available there. Maybe I can develop methods of getting that information. One of my projects is to try to figure out what is in the IV-D program.

One thing you need to be aware of is the fact that much of this information is already in the eligibility files. The eligibility file is going to reflect a lot of the information dealing with the insurances available to that absent parent, because the mother has already told you that at the intake process. Again, every child has a father, who has potential employment, which has insurance. And when I start looking at some of these bills, I don't have any better sense than to go looking with my IV-D people; being on the inside, I get on the phone right now. We're not computerized in that area. I call them up, and you know them by first names. The first question they ask is who are you? I'm Russ Ward from the State office - support enforcement. Well I got my foot in the door, they don't tell me it's none of my business or what have you. That's why I like staying where I'm at. Once they get this thing on the computer, I won't have to go after these people. So the end result is that all of the IV-D propoganda goes out from our office with names to contact in the State office. My name happens to be involved with it.

Question: It is especially a problem in our State (New York), to get the insurance to repay after getting the court award, because we have a family court. Our family court judges are in many instances hostile toward any medical support. They have the feeling that the mother has Medicaid. I don't know how they make that connection, but they think by having Medicaid she doesn't need medical support. So they certainly won't bring the father back in for that payment. We were wondering if, under our IV-D program, there is a possibility of some sort of subrogation of that portion of the father's insurance which applies to his beneficiaries so we won't have to see him again?

Answer: I hadn't thought about that. Does anyone know if you can get the subrogation right through this man's insurance?

Question: Would it have to be done on the Federal level?

Answer: Yes.

Comment: We have been around Washington proposing this particular thing. We would also like to receive from absent parents the portion of the bills that applies to our client.

Comment: I'm not sure if you're going to get a lot from the IV-D people. They've got their own ox to pull and it's not going in that direction.

Question: What difference would it make to IV-D? It would keep us off their backs.

Answer: The added imposition on that absent parent. Let's face it. I think they're facing a real battle as far as support is concerned. We have a whole mass of unworkable files. The simple reason that they don't have to do it is they've got their own problems.

Comment: We've possibly raised more questions than we have resolved. These are some of the areas where we have a lot to do as far as the absent parent is concerned.

TPL GENERAL SYSTEMS DESIGN

Michael Donley

Chief, MAMIS Division

Pennsylvania Department of Public Welfare

For everybody's information, my position with the State of Pennsylvania is that of Chief of the Medical Assistance Systems Development Division.

Since May of 1977, Pennsylvania has been involved in trying to design and implement an MMIS system, and in that time span we have implemented two provider groups into the system. They include podiatrists and dentists. At the same time we are now, with the cooperation of CAPD, trying to design a TPL system.

It was implied this morning that we may already have a system, but I emphasize that at this time, Pennsylvania does not have a TPL system. We are designing it. A CAPD team will probably have a design package in final form by the end of the summer. Right now, it is in draft form. It really has not been approved and we are still making modifications to it. The actual computer programming specifications which will put it into effect will probably not be done until the fall. So, we are still a long way from implementing a TPL system within the State of Pennsylvania. As a matter of fact, Pennsylvania is now negotiating another contract with Touche Ross Company, our consulting contractor trying to help us implement MMIS. Tentative plans for the next provider group will be implemented in January or February, 1980. We have quite a few provider groups to implement.

We plan to submit the form that you have seen this morning to the county boards, who are the individuals that actually enroll recipients and will be charged with the responsibility of gathering the third party resource information. We plan to start that in September. Now, that is very, very tentative. As I said, the actual form has not really been approved by the various offices that must approve it before it is out in the field. In Pennsylvania, the Office of Income Maintenance controls the entire recipient eligibility file whether it is food stamps, cash, medical, whatever. They control that one file and we as medical assistance data processors use that same file.

This first transparency basically outlines Pennsylvania's concept of the major functions of the TPL system we are going to implement (Exhibit 1). As alluded to this morning, most people are going cost avoidance. This really speaks for cost avoidance. The reason that we are going cost avoidance is resources. It is more economical and we want to do something very quickly to get a handle on other resources to save money. This is not to say that down the line we will not implement a recovery benefits system, but I believe it will be separate from the claims processing system.

Now, there are three major questions. The first one is basically getting the information from the third party liability resource file. The second is actually taking that resource file and using it to check invoices to determine whether there is a third party liability claim that is a candidate, or what you want to do with it once you determine it is a third party liability. The final major function would be reporting on that activity. What do you do with the information; what have you decided; and how do you report on the activity that you decided to follow with that TPL claim? I will try, in some detail, to explain each one of those functions.

Exhibit 1

THIRD PARTY LIABILITY SUBSYSTEM

A. FUNCTIONS

1. Real-Time File Maintenance

   A) Add
   B) Change
   C) Delete
   D) Inquiry

2. Invoice Interface Processing

   A) Rejects Invoice Line Items
   B) Pends Invoice Line Items

3. Reporting

   A) Transaction Activitiy
   B) TPL

I want to re-emphasize that this is a very, very simplified informational flow diagramming each part of the system. It in no way represents the flow in its entirety. It is just more or less a block diagram to highlight the most important information as far as TPL is concerned. This morning you used Pennsylvania's invoice (Exhibit 2), but I want to mention that we are not using that MRDF at this time. If everything goes according to plan, our basic mechanism to get the information into the system will be through that form. I want to emphasize that the county boards are the people who will fill out this form when a recipient applies for his/her initial eligibility certification or when he/she reapplies in the next six months, or when there is a change in eligibility. When he/she comes in and speaks to the caseworker, it is at that time that this MRDF will be filled out.

What will happen is that information will be entered through a CRT and it will interface with a TPL file programming module that will allow the information to be added to that TPL file, or allow it to be changed or deleted (Exhibit 3). Also, it will have the capability to inquire against that file to see what informtion is out there. Now, before anything is done to the file, there are a series of edits that will be done to the actual transaction when it is entered into the system. The major edit you will be concerned about is that the recipient number on the form must be on our recipient eligibility file. If it is not, it will not get out on the TPL file. It will be put to a file for correction later, where the problem is researched and resolved. Anything that is good will be put on the TPL file. The edits are more inclusive than just an eligibility check, but there is obviously some feeling that it is a normal data processing basic flow that you might be familiar with. All information that is entered, whether it goes on the TPL file or whether it goes on the correction file, will be put into an activity file for reporting purposes. So that means that anything that was done to that file will be printed out, whether it was added, changed, or deleted. Inquiries will not be put out there, obviously. You will get a report showing what happened to that file. This report will be matched with the actual. That's called the log of the MRDF forms that are accepted by the central office in Pennsylvania. All these forms, when they are filled out and entered into the system, are sent on to the central office in Harrisburg. That and the TPL unit in the central office will have those forms microfilmed. They will also have them logged and annotated with a certain number for control purposes. Those forms should be logged on a daily basis, or however often these reports come out, with that activity. There should be that type of minimum control for what happens to that file. Now the report file shown here is a history file. There is some discussion when you delete an actual resource for the recipient on the file; what do you do with it? Well, you have two options that I can think of right now. You can close out that person's coverage date, perhaps, on that particular resource or you can actually take it off the file. Now, if you take it off the file you might want to save it somewhere for a period of time for recording later and, perhaps, for inquiring. In either case, that is what that TPL history file represents.

You have seen the MRDF already. I'll just go across the top. What we are talking about here is that each recipient has his/her own identifying number. There is enough space on this form to record at least three third party resources. Each one contains the name of the employer, the address, the

MEDICAL RESOURCE DOCUMENTATION FORM

CONTROL NUMBER
DO NOT USE

1. RECORD NAME
1A. SOCIAL SECURITY NUMBER
2. COUNTY CODE
3. RECORD NUMBER
4. CATEGORY/CAT. GRP
5. CHK. DGT.
6. DISTRICT
7. DATE (MONTH DAY YEAR)
8. CASELOAD NUMBER
DO NOT USE

RESOURCE A

10. LINE NOS. COVERED
11. TYPE INS.
12. NAME OF INSURANCE CARRIER
13. CLAIMS OFFICE ADDRESS (STREET, CITY, STATE, ZIP)
14. GROUP, CONTRACT, POLICY NO.
15. GROUP NAME, IF APPLICABLE
16. DATES OF COVERAGE FROM: (MONTH DAY YEAR) TO: (MONTH DAY YEAR)
17. POLICY HOLDER NAME, IF NOT RECIP. (LAST NAME, INITIAL)
18. POLICY HOLDER ADDRESS, IF NOT RECIPIENT (STREET, CITY, STATE, ZIP)

RESOURCE B

10. LINE NOS. COVERED
11. TYPE INS.
12. NAME OF INSURANCE CARRIER
13. CLAIMS OFFICE ADDRESS (STREET, CITY, STATE, ZIP)
14. GROUP, CONTRACT, POLICY NO.
15. GROUP NAME, IF APPLICABLE
16. DATES OF COVERAGE FROM: (MONTH DAY YEAR) TO: (MONTH DAY YEAR)
17. POLICY HOLDER NAME, IF NOT RECIP. (LAST NAME, INITIAL)
18. POLICY HOLDER ADDRESS, IF NOT RECIPIENT (STREET, CITY, STATE, ZIP)

RESOURCE C

10. LINE NOS. COVERED
11. TYPE INS.
12. NAME OF INSURANCE CARRIER
13. CLAIMS OFFICE ADDRESS (STREET, CITY, STATE, ZIP)
14. GROUP, CONTRACT, POLICY NO.
15. GROUP NAME, IF APPLICABLE
16. DATES OF COVERAGE FROM: (MONTH DAY YEAR) TO: (MONTH DAY YEAR)
17. POLICY HOLDER, IF NOT RECIP. (LAST NAME, INITIAL)
18. POLICY HOLDER ADDRESS, IF NOT RECIPIENT (STREET, CITY, STATE, ZIP)

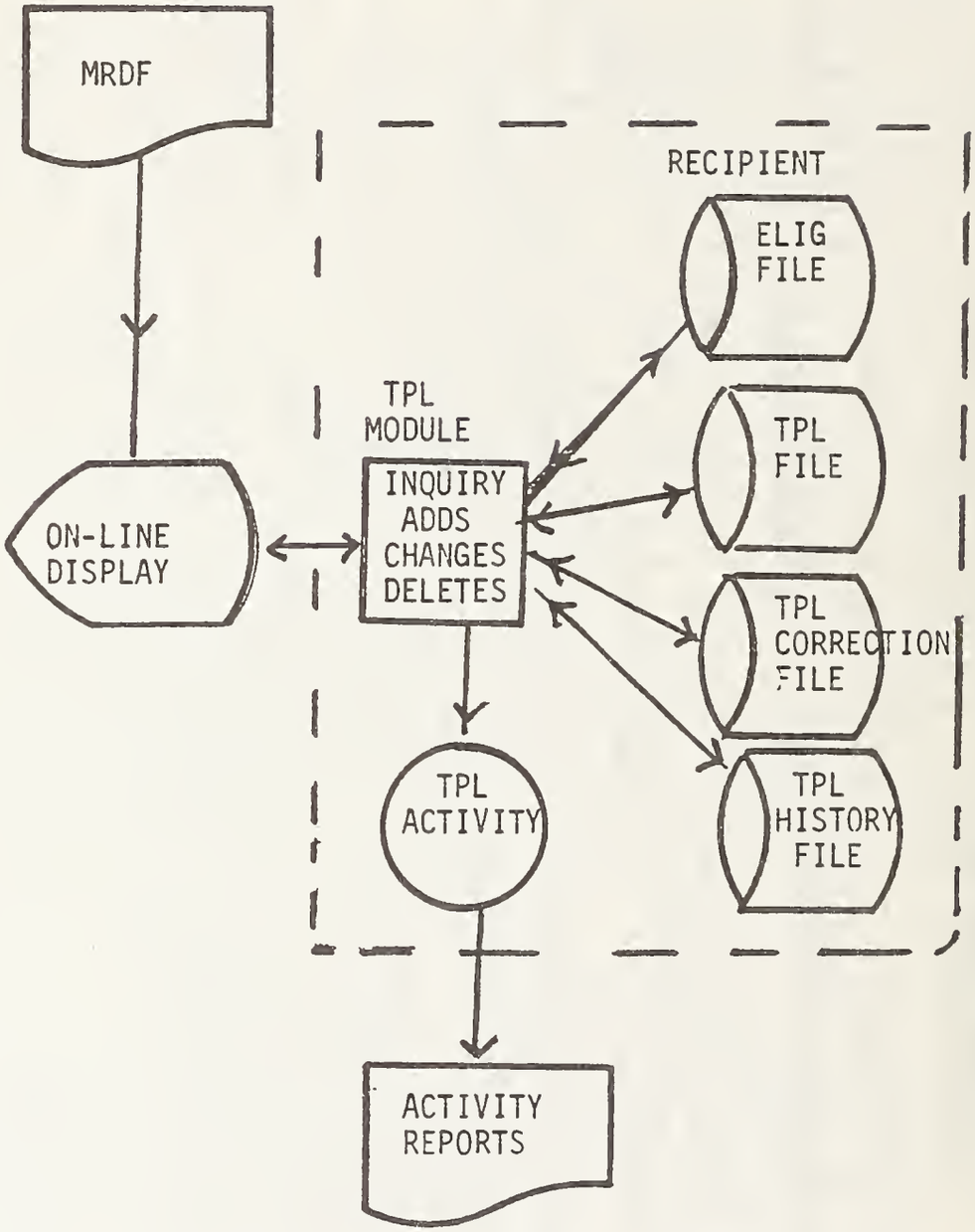
ATTACH ADDITIONAL FORM(S) FOR FURTHER RESOURCE COVERAGE

Exhibit 2

Exhibit 3

TPL

1. REAL TIME FILE MAINTENANCE



name of the recipient, and the number of the recipient. The line contains numbers for that recipient and designates the insurance policy coverage. There's a four digit field. The first two represent the actual code that will be assigned to the various insurance coverages like Blue Shield and Blue Cross and so forth. Each one will be assigned a number. The program office in Pennsylvania has selected the top thirty commercial firms through the help of the insurance commission in Pennsylvania, which processes 92% of all the health insurance activity in the State. So they got a list of the top thirty, assigned them numbers for identification, and assigned default numbers to all other insurance companies for identification purposes -- like a 99.

The third digit was to give us the option to identify the coverage more specifically. For example, does it have dental? Does it have vision care? Does it have major medical?

The program office has told us that through their research they can tell by the cover on the policy whether you have major medical. The recipient can tell you whether he/she has dental or vision care. They want to try to build in the capability to have that information available, if it is available. If it is not available, then it won't be filled in. The other digit is whether there is a court action. This will come into play when we process the claims.

This is a very basic diagram of the invoice processing within the State of Pennsylvania (Exhibits 4 and 5). You have seen the invoice. I would like to explain that an invoice in the State of Pennsylvania is that sheet of paper which has many lines on it. Our dental has seven. Each detail line is the service provided, the charge the provider is asking for, the procedure and type of service, the date of service, emergency code, and so forth. Now our system is probably similar to the other systems here, yet not exactly the same. It is broken up into two different processing phases. All the invoices that come in are run daily against a multitude of edits. There are literally hundreds of edits. Those claims that are clean are saved. When I say "clean" I mean that they have no errors on them as far as the daily integrity edits are concerned. They are good claims. These are all saved every day and then processed into a weekly cycle - that means once a week. Those claims are taken into another set of programs that do further editing (such as duplicate checking, frequency of checking and that type of thing). They then produce the actual payment instrument. That is, basically, the processing that goes on within Pennsylvania's system.

What happens when this invoice comes in? The claim, before it is even considered for TPL determination, must be clean. Once it is clean and ready to go to the payment process, we look at the information on the invoice, line by line, to determine whether there is a possible third party resource. That is one mechanism.

On the claim, you have the other resource indicator, the data set. That's one possibility. If there is a paid amount in the other insurance paid field and no other indication of the invoice for the net, that is an indication it is another possible candidate for TPL. The diagnosis and procedure code is also an indication for traumatic experiences and so forth. These things are on our procedure file. They are marked with a traumatic diagnosis procedure code.

TPL

2. INVOICE PROCESSING INTERFACE
3. REPORTING

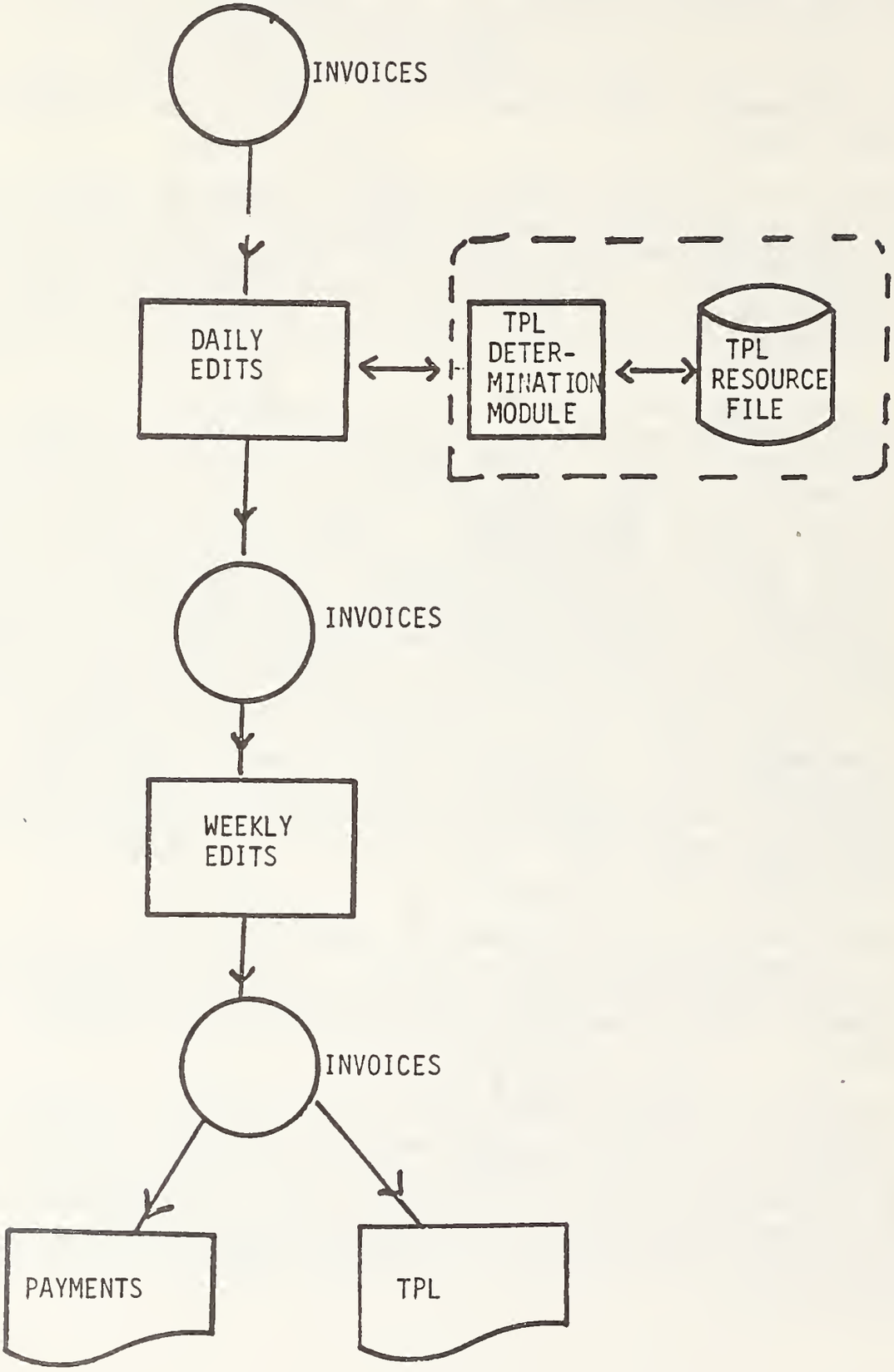
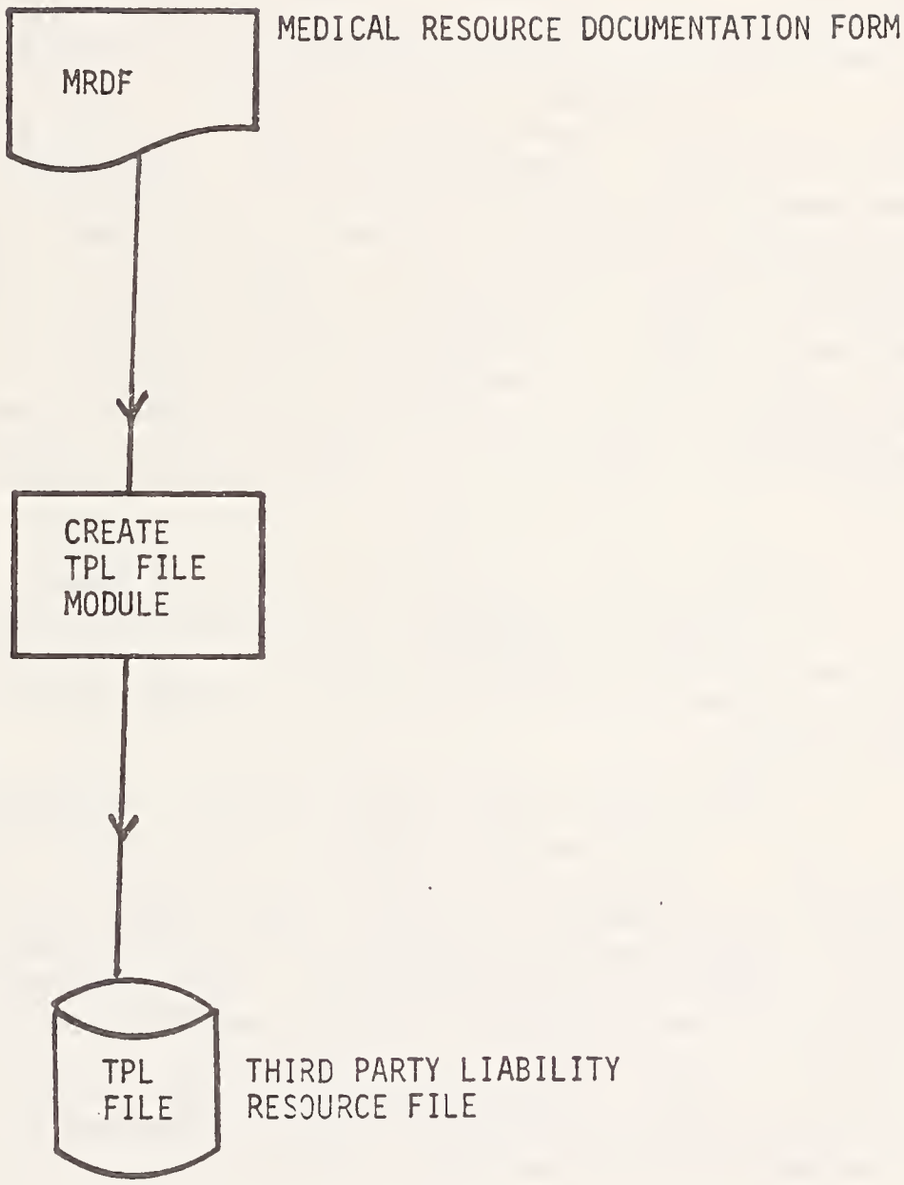


Exhibit 5

TPL

4) INITIAL TPL RESOURCE FILE CREATION



The other mechanism is when the actual invoice goes against the recipient eligibility file. On our eligibility file we have these eligibility resource indicators that you saw on the claim. Each recipient has indicators on his/her record telling whether he/she has Medicare Part A, Part B, CHAMPUS, or what have you. If he/she does have that marked, that is taken into consideration. That makes the claim a candidate. If the person's age on the recipient file indicates the he/she is possibly eligible for Medicare, we mark the claim as a candidate. After all these things are done to each invoice, the actual line on the invoice now becomes a candidate for TPL determination. At that time each line on the invoice is passed through this TPL determination module. For each line it examines the dollar. There are a lot of parameters that are built into this determination module. I don't show those parameter files, but they would be in that particular logic of the programs. The parameters are like the following. The dollar limit that every type of service and procedure must meet -- if it exceeds its dollar limit, will give a point, targeting it as a possible candidate. If it doesn't exceed the dollar limit, we are not interested in it. This is a program policy decision. These things are built in to give the program office flexibility to use this information. You look at the file and say, does this recipient have third party resources out there? If he/she does, then that makes him/her a candidate. If it is one of those coverages that we talked about on the resource file, we would not pay and somebody would, then give that claim line a point. We keep adding up these points for the claim lines. You determine the priority of the resources on this file after going through these criteria. For example, the recipient may have more than one resource. Which one do you send it to? The priorities are going to be set according to what covers what. (What type of insurance policy covers what type of procedure.) Then, all of the parameters that were assigned points add up to a certain level of certainty. These levels of certainty will then determine what you do with the claim. Are you going to pay it? Are you going to pend it? Are you going to reject it?

The decision to pay it will be made by the policy maker who sets these criteria. I want to emphasize that in the system we are trying to design, we will make it flexible enough for you to either say "Yes, I want to pay it" or "I want to pend it today" or "I want to reject them." This is the purpose of our concept.

If you decide to pay, you just send it on through and it will go through the weekly. If it passes all its edits, it will be paid. If you reject it, it will be passed on to the weekly for reporting purposes only. If you pend it, it will be passed on to the weekly for reporting purposes. Once these invoices get to the weekly, they once again have to pass all the weekly edits. If they don't pass the weekly edit, all bets are off. Everything is wiped out. No longer do you have the TPL candidate. It goes out to the normal claims management pend reports and says, fix this claim. If it is a duplicate, there's something wrong with the invoice itself. They don't know it at this time even though the daily determined that it was a TPL candidate. It no longer is. We want clean claims.

If it does make it through the weekly, it is ready for payment. At that time, the weekly module determines what it is going to do with it. If it is paid, it goes out to the payment section and is put on the remittance advice. The remittance advice in Pennsylvania contains each provider's claims that were processed by recipient's name, number, claim identifying number used by

the system, what happened to that claim, the edits that occurred when it was processed out, and any information that can be printed on the remittance advice about the activity that went against that claim.

If it is pended, it will also go to remittance advice. It will tell the provider that his/her claim is pended in the system for further consideration. If it is rejected back up in this determination module, what is extracted from that is the name and address of that resource that we decided to send the claim to. So, the rejected claim will go out on the remittance advice, and printed along with all the information will be the name and address of the third party that we feel is responsible for payment of the claim. We will be telling the provider through a code and, obviously through education, to send those particular line items, not the entire invoice because we will be able to reject claims by line item. We have to tell the provider which line items can be sent to which particular insurance company.

Question: What is the time frame when paying a claim between the time it comes into the system and the time it gives you daily editing?

Answer: You have to understand the actual processing. We do not print the check. The Treasury Department prints the check. We create a tape with the check information and it goes to the Treasury. They marry that check up with our remittance advice and send it out. It comes back to the comptroller and so forth. We couldn't get the authority to write the check. So what happens, we can process a clean claim probably within two weeks. We could process a claim that has average errors on it, and has to be corrected, probably within four weeks or thirty days. But it takes the Treasurer anywhere from ten days to two weeks, perhaps, to print the check. So that adds on to when the provider gets this information.

Question: I guess my question is, if the recipient gets a line item and that specific service is covered by more than one of the recipient's health resources, are you going to print both of them or all three of them?

Answer: The one that was picked as priority will be printed. These would be picked by the TPL unit or the program office in our case. It would be their policy on how they wanted to control that file. As I said, we are trying to give them flexibility. I am not saying it will be easy, but at least we are going to attempt it. We can implement that concept.

Comment: When you reject a claim and a recipient has multiple coverages, you identify back in priority order the number one insurance company that should be paying for this service line. It adjudicates the claim, but it doesn't cover the entire fee or the entire service and the provider bills that you show a credit.

Answer: It will come in as another claim, another invoice with a credit. It will have on the invoice other insurance paid and amount of dollars.

Question: Right, and presumably there's a dollar amount owing still by the State. Will you benefit recover that on that dollar amount that you might pay?

Answer: If there are no other resources.

Question: Will you go to the second or the third or the fourth in priority?

Answer: We will never pay as long as there is another resource that we know about. We will send it to the resource. Now our existing system will be modified to allow for that type of editing.

CASUALTY

Jerome Hansen

Chief, Recovery Section

California Department of Benefit Payments

Casualty insurance includes all these things and, perhaps more: auto, homeowners, commercial, product, medical services, worker's compensation, and other liability protection programs. They should all be around depending on what your insurance commissioner and your State wants to recognize.

Casualty, as we discussed earlier, is different from health insurance in that you never have any idea of what kind of money you are going to get out of casualty until somebody assumes the responsibility to pay something. They may not assume the liability for the event, but they will settle. They will say they aren't liable for that accident; we really aren't liable for it, but just to get you off our backs and to get this matter resolved, we will settle with you. One thing you have to examine then is how a liability claim is paid. You need to talk to the insurance commissioner about this so you can get a graph of the casualty program in your area. I would suggest that if you have major casualty carriers doing business in your State, State Farm or whatever, talk to your regional manager to find out what his/her program is. How do they pay? How do they handle claims? How do they compromise? On what basis are you going to do business with them? You may think right now that these people are the enemy, that they try not to give you money, but I suspect that, like health insurance, you will find that these folks are business people whose job is to sell insurance, pay premiums and make money. They do that by paying their obligatory premiums in an efficient and economic manner. It has been my experience with casualty carriers that they are similar to health insurance carriers. What kinds of questions or areas of interest do you have in casualty?

Question: Our experience in California has shown that of all the casualty cases, maybe 30% or 40% involve attorneys. What percentages of cases that your State adjuster settles would involve attorneys?

Answer: You might think the attorney involvement is 30% or 40%. The attorneys are involved in bigger bucks. They are business people too. You get many claims where someone gets a sprained back or a strained neck and goes to the emergency room. Emergency room fees are $125 for a few x-rays and basic care. For small cases, I am suggesting that you hand it to the claims adjuster. Maybe the claims adjuster is going to write a two party check to you and the beneficiary. This forces the beneficiary to come through you. I read a publication that suggests we not have a two party check. That's proposed within my State by the Department of Finance. Their attorney suggested that we should never have a two party check. It's just a little policy problem within the State. We encourage them and they say no, you don't want to do that. That presents a problem.

Comment: You were talking about the percentage of cases that involve lawyers. In South Carolina, nearly every welfare client has a lawyer. I would guess that better than 75% of our casualty claims are handled through lawyers, especially if they are in excess of $300 (then it is probably closer to 90%).

Question: What do you do when your judge awards a relatively small medical payment in the award that will not cover the bills, and there is a very large pain and suffering?

Answer: You suffer like the patient.

Comment: The California statute addresses itself to the settlement per se. Our law states that we cannot get more than 50% of the net amount to the injured party. It states that our share of the recovery will be reduced by 25% to contribute to the injured party's need to pay for attorney's fees. Our law also indicates that we will pay our fair share of court costs and related investigatory costs. We do not in fact have the problem of which you are speaking. In worker's compensation, the worker's compensation judge frequently does the kind of thing you are talking about; our law precludes them from doing that and they're not too pleased.

Minnesota's law, which came through worker's compensation, says that, if in a worker's compensation case there is a request to adjudicate the claim and the plaintiff isn't satisfied with what the carrier wants to pay, they can take it to the worker's compensation board and adjudicate it. The Minnesota program is assured of 100% of its costs plus 12% interest on all the money that wasn't paid to it during the original event.

Medical malpractice is an interesting area to think about. We send letters out to everybody that has had some sort of a trauma. Trauma, as we define it, involves fracture, lacerations, or any number of things. We use the International Classifications of Diseases which has a wide range of codes. The codes are established internationally by a World Health Organization subunit. We use it to get our computer to do things. We use it to send out letters to people asking them for information about their injuries, where and how it happened, and if anybody else was responsible for it. We tell the addressee that if you don't understand what we mean, call us on the phone, at no cost to you. The message goes out in English and Spanish. We receive a good response on the phone. Our response on the mailed stuff is about 55%. We have just taken over this work area and I'm not sure how we're going to bring that percentage up. We do know that we have some edits for high dollar cases where we will, if necessary, send field people out to check the problem (phone the hospital and the lawyer, get the police reports, etc.). In malpractice, we send letters out. We may get the ire of the physician who asks if this is trying to get the patients to sue. We have only had that happen once or twice. It's more of a political problem than anything else. The physician may have politically supported somebody who calls on you and asks what are you doing to this guy?

We subscribe to a news clipping service (very cheap). We very narrowly define what we are interested in to the news clipping service. We are interested in accident cases involving medical payments. Any time they run across that kind of story in a newspaper, they clip it out and send it to us. It costs around 10 or 15 cents. We may go along for three, four, or even twelve weeks and never find something, but when we find something it pays for that year of newspaper clippings plus the next one. So it is very inexpensive.

Another case finding device in casualty is looking at your ATD population. If you haven't reviewed that population to see who has litigation going and who does not, I would suggest doing that at some point when you have the analyst strength to do it. We took a look at the rehabilitation hospital in Southern California and, with the consent of the hospital administrator, started reviewing 187 people who were there supported by Medicaid. The object was to find out from the hospital how many people on Medicaid were involved in

litigation? The hospital needed to know because that was a source of payment to them. We wanted to know for the same reason. We went around to each of these patients and asked about the event that caused them to be there. Were they considering or were they, in fact, involved in litigation. We found five previously unknown litigations. Now that doesn't sound like too much out of 187, but none of those cases cost the taxpayer less than $40,000. Five cases x $40,000 equals a lot of money. So, if you have a rehabilitation hospital or rehabilitation center in your State, plus a concentrated ATD population and analyst strength on your staff, go ahead and see what you obtain.

Another thing relative to casualty is that payment settlement is frequently detected by caseworkers. Russ Ward has mentioned, in prior sessions, the benefits of the caseworker identifying a major case. You collect the money and get back to that caseworker's department, show the check and say, "What a nice person you are to have identified this case." You put the person's picture up on the bulletin board and put it in a newsletter. It gives everybody else the idea that we really do care that they report this stuff. We have a system of caseworkers identifying cases for our system where they note that there has been a settlement.

Comment: In casualty cases, do homeowners have something like product liability? You don't have to have negligence to collect. If a person got hurt there, he/she will generate a few bucks back.

Comment: Americans frequently have more than one car in the driveway. If all those cars have insurance and somebody in that household is injured, the Medicaid portion on each one of those policies will frequently stand. In other words, you can collect from each one of them, even though the other cars aren't involved. They may be in a totally separate accident, none of the cars may be involved, and yet they have the medical care coverage for automobiles accident related injury. It depends on how the contract is written, but you may be able to stack all those policies and use each one of them to the extent that you need payment. If all of those policies have been exhausted and they happen to be under a homeowner's policy, you may be able to switch over and get into the homeowner's policy. Again, collectors know these kinds of inquiries and seek maximum information. It may seem extraneous at the time, but you try to get as much as you can. You should go after many sources until you get all of your money paid or it is not cost effective to do so.

Comment: You might mention that, in most of those cases, a claim is made against Medicaid on a first come, first served basis.

Comment: That's right. Any other comments on casualty? Casualty is easy work, and very lucrative. Sometimes you have to wait a long time to get your money. It definitely requires good receivable-management-accounting systems. Something that you can, through record keeping, adjust the dollar value on cases you are going to pursue to maximize resources. As you adjust your resources up to your case level and vice versa, you can keep track of the number of cases and the dollar volume. Then, at budget time when they ask what you are doing, the fiscal reviewer can say, "I did this, but I abandoned collections on all of these things because I didn't have the re-

sources to go after them." Bimonthly, I send reports in to my boss keeping him up to date with what I did, and what I abandoned. It's necessary to tell your management what you can and cannot do in terms of money.

In the casualty field, you should create an opportunity to meet with adjusters, so you become an individual. You should have somebody on your staff that is good at public relations and knows something about the casualty business. That pays good dividends.

All over the country there are things called Index Bureaus. Index Bureaus are central areas where casualty insurance companies can ask them if they have anybody else who claims to be interested in a case. This individual is taking us for $15,000. The Index Bureau will have a little card sitting there and it will say that Allstate's got an inquiry and Aetna's got an inquiry. Then, the Prudential Company, who has asked about this, will get a listing on all these other carriers asking about this case. The Index Bureau will also tell each of the other carriers about any new inquiries. This is one of the ways they are detecting fraud within the casualty program. I, as a Medicaid agency, tried to join the Index Bureau and was advised by the national office that I am not an insurer. Thus, I cannot belong to the Index Bureau. However, if you are friends with these helpful people, you can occasionally get an informal question asked and answered.

Also, our cooperative State Department of Transportation is self-insured and are members of the Index Bureau. We can go over and ask them to ask the question.

Comment: I would like to add one thing. I was a claims adjuster before I worked for the State. In our State, in addition to the Index Bureau, we maintain a historical file dating back seven years. If you were to have a worker's compensation claim, a back injury or whatever, originally paid off by worker's compensation, we can trace it to its origin.

Comment: This brings up the issue that you're missing a resource when somebody has an APB type claim and you don't find out that they should have a worker's compensation settlement coming to them.

Comment: My name is Ann Gordon. I'm with the Attorney General of West Virginia. I am assigned to the Department of Welfare, Medical Services. We haven't done any compromising yet.

Question: What is the art and science of compromise?

Answer: Well, I was in private practice for a year and a half and did some insurance defense work then. In those cases we went back to our insurance carrier, the folks we were representing, and said, "Listen, we don't want to take this to court because we've got a bad case," or, "It's going to cost you too much. Would you give the authority to compromise for a minimum of a $1,500 claim? Can I offer $500 for this claim?" Your insurance carrier may say, "Yes." So you go back to the other lawyer and say that we are willing to compromise for $500, "Will you release the claim?" Then, they may come back and say, "Gee, you are trying to buy us off for nothing, we'll go for $1,200." It goes back and forth -- getting authority back from your client and the other lawyer gets authority back from his/her client. Soon you may come up with a legitimate compromise offer.

Comment: Something Maryland has that we find to be very productive, is when we are asked to compromise, we will only reduce by a percentage equal to a reduction in attorney's fee. It has a tendency to eliminate just any request for reduction. Normally speaking, if the attorney is willing to reduce his/her fee, it's a legitimate case and something should be done. We have found it very effective to do it that way.

Comment: Two things. One, I come to you and tell you that this case is worth $300,000, but the liability is only worth $50,000. Therefore, I want you to reduce your lien by the reduction in the case value versus the liability. Knock your lien off. You've got a $10,000 lien against my case. However, the case is worth $350,000 and it's beyond my control if your client has only a $15,000 policy. $350,000 down to $15,000. Back off your lien off that ratio. We refuse to do this.

Comment: I'm confused who's got which $350,000.

Comment: The attorney for the plaintiff says this case is worth $350,000 if we pursue it. They only have a $15,000 liability policy and we decide not to pursue it in court. Therefore, I think you ought to reduce your lien on ratio from $350,000 to $15,000. Take your $10,000 and reduce it that far.

Comment: That sounds like an excess case. That's a very dangerous situation for an insurance company. If they have the money and they have a case liability, they better cough up their $15,000, because if they try to fight that case and lose it, they may expose themselves to $350,000.

Comment: As a Medicaid agency, we have frequent experiences in which attorneys come at us with that kind of rationale. We couldn't be concerned about the $350,000, but we are concerned about how much of the $15,000 we are going to get. It's an argument that attorneys try to beat you down on your lien. In this area of the art and science of compromise, or horse trading, it's a matter of trying to look at needs and making determinations of that kind.

Question: Our State of West Virginia is very small. At least in Charleston, we end up meeting all the members of the bar; a lot of personalities get involved. It's obvious that with some people you can take one tactic and with other people you have to go to court and get good judgments and settlements because the other lawyers know that they are really hard nosed about it. Other people are less severe. You offer me something and I'll take it just so I don't have to go to court. You have to know the personalities of the people you're dealing with. It's not a science.

Comment: In New Jersey in situations (other than no-fault), such as those worker's compensation where we get paid in full, we sometimes would find, because of cooperation with medical assistance and public welfare, that a client had been called in and had signed a reimbursement agreement with welfare.

That enabled us to pursue, if feasible, the total amount of our claim. If we compromise it, welfare is only going to pick up the balance. So, we have an agreement with them that we will go straight ahead and collect as much as we can and whatever is left can be taken down to $200.

Comment: I was going to point out that when you are talking about payment you must be careful with the recipient, otherwise, there is no sense for the recipient to bring suit if you recover it all.

Comment: That's why I said 50% maximum of what the recipient collects.

Comment: We have, of course, some situations everybody has. The attorney calls in and says, "Look, everyone has to compromise their claim, how much are you going to compromise on the Medicaid claim? If you let us know what your settlement figure is, then we will talk about compromise. We are not going to give you our figure to give out."

Comment: The world of compromise is in fact the world of mystique. One of my problems as a program manager is that I have $350,000 in legal fees for State attorneys that I pay every year inside my budget. Though I would like to, I don't have any control on what those people are doing about compromising. There is a lot of art, but no factual science of compromise. As you know, claims adjusters are interesting people to talk to in the area of compromise. If you go back to your State and you don't know any claims adjusters, go meet one. Ask your insurance agent to introduce you to some. Because in the area of casualty insurance they'll do a lot to help you. They do it day in and day out. Persons in private practice do it occasionally. While they have good skills, they don't have the skills of the claims adjuster who is making those adjustments day in and day out.

PROBATE

Frank Traglia

Chief, Division of Medical Assistance Recovery

Maryland Department of Health and Mental Hygiene

In the environment of rising costs and increased calls for fiscal restraint, State Medicaid agencies are under increasing pressure to hold down program costs whenever and wherever possible. A means to accomplish this, without decreasing the quantity or quality of medical care provided to recipients, is through the development of a comprehensive Medicaid recovery system. Based on enabling Federal legislation, State agencies are given a number of opportunities to save Medicaid dollars.

The areas offering potential recovery are many and varied, encompassing both the very simple and the very complex. These areas of collection activity include tort liability, worker's compensation, medical child support (Title IV-D), and recipient resources. All represent worthwhile undertakings for State Medicaid agencies and have been developed by an increasing number of States. One area, however, has been overlooked by many States even though it offers great collection potential at little cost. This is the area of probate or estate collection.

In Maryland, the Medical Assistance Program's estate recovery system has been a great success. Begun in 1971 as one of the first areas of Maryland's recovery effort, estate collections have saved Maryland taxpayers over $2 million through Fiscal Year 1978. Yearly collections, which were $8,000 in FY 1972, have averaged $500,000 over the past two fiscal years. 1979 estate collections will continue this trend. This return has more than justified Maryland's investment in estate collections.

Estate is a word describing a legal entity created to handle the assets and liabilities of a deceased person. It is established under jurisdiction of a probate court which, in addition to estates, handles the certification and registration of wills and guardianship of minors and incompetents.

An estate is opened when an individual, standing as a relative, interested party or creditor of the deceased, files an application with the probate court in the jurisdiction in which the decedent lived or owned property. If the application is approved, the individual applying is named the estate's executor or administrator and is responsible for the proper handling of the estate's affairs. (In Maryland, this individual is called the estate's personal representative.) This responsibility primarily encompasses the identification of the decedent's assets and the satisfying of the decedent's liabilities.

Upon the appointment of an executor, a Notice to Creditors is published in a regular or legal newspaper, listing the name of the decedent and the estate's executor, the date the estate was opened and the date the estate closes to creditors. All probate laws subject creditors to a time limit in which claims must be filed to be paid. In Maryland, limits are one month for a Small Estate (total assets under $7,500) and six months for a Formal Estate (over $7,500).

The probate court requires a complete accounting of the assets and liabilities of the decedent at various times during the life of the estate. Such an accounting, if not required sooner, is always necessary before the estate is closed. Copies of this accounting are usually sent to all

interested parties in the estate. Once submitted to, and approved by the probate court, the executor is authorized to distribute the assets of the estate to the estate's creditors and/or heirs. The estate, after the distribution of all assets, is closed.

A creditor secures payment from an estate by filing a formal claim with the probate court under whose jurisdiction the estate was opened. The claim must be submitted within the time period, and in the form prescribed for creditors by local law. If the executor disputes a claim, a hearing is held before the probate court which determines whether or not the claim must be paid. It is the responsibility of the probate court to see that valid claims, properly submitted, are paid by the estate.

The authority for estate recovery is contained in 42 USC 1396(a)(18) (Exhibit 1). The statute limits recovery to those services received by a recipient after his or her 65th birthday and only when such recipient is not survived by a spouse or child under 21 or a child who is blind or permanently and totally disabled. This statute is enabling legislation only. It specifies an area in which a State can take action to recover Medicaid expenditures; it does not mandate such action.

In order for a State to have a firm legal base for estate recovery, specific State legislation authorizing such action is necessary. Maryland fulfilled this need with the passage of specific authorizing legislation in early 1976 (Exhibit 2). The legislation not only provides the program with authority for estate recovery, but mandates consideration of possible hardship situations in determining when claims should be filed, as well. This hardship provision is very important and desirable in that it allows for the waiving of claims in those instances where the filing of a claim would be against the best interests of the program and the recipient's survivors. No advantage, for example, can be gained by a Medicaid agency forcing the sale of a deceased recipient's property if the property happens to be the home of the recipient's invalid sister.

The statutory authority needed on the State level is straightforward and based on clear Federal authority. Because of the recipient safeguards contained in the Federal statute (and the additional safeguard concerning hardships which a State agency should ask for), estate legislation should encounter little opposition in any State legislature. Any opposition that surfaces would be hard pressed to ignore the return from investment potential represented by estate recovery.

The key to any successful estate recovery system is the development of means by which to identify those deceased recipients against whose estates claims can be filed. Once identification is accomplished, the actual filing of claims is quite easy. Maryland's system relies on two major notification sources, both centered on the county level: the local Departments of Social Services (LDSS) and the Register of Wills offices. The following discussion will examine both sources and follow referrals through the entire system to the filing of a claim.

The LDSS notifies the Division of Medical Assistance Recoveries (DMAR) of the death of Medical Assistance recipients via Form 1169 (Exhibit 3). A Form 1169 is sent to DMAR for every deceased recipient with assets of over $1,200

Exhibit 1

ual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or is blind or permanently and totally disabled; and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

(18) provide that no lien may be imposed against the property of an individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or is blind or permanently and totally disabled) of any medical assistance correctly paid on behalf of such individual under the plan;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution;

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance;

Editor's note. — Chapter 490, Acts 1976, designated this section as § 42E but since a § 42E had previously been added by ch. 489, Acts 1976, the section added by ch. 490 has been designated as § 42F herein.

Section 2 of ch. 490 provides that the act shall take effect July 1, 1976.

§ 42G. Same — Claim against indigent's estate for payments made.

In accordance with applicable federal law and regulations, including those under Title XIX of the social security amendments of 1965, the Department of Health and Mental Hygiene may make claim against the estate of an indigent or medically indigent person for the amount of any medical assistance payments made on his behalf by the Department. The Department shall waive its claim if it determines that enforcement of the claim would result in substantial hardship to the dependents of the individual against whose estate the claim exists. (1976, ch. 663.)

Editor's note. — Chapter 663, Acts 1976, designated this section as § 42E, but since two earlier acts had each added a new section designated "§ 42E" the section added by ch. 663 has been designated as § 42G herein.

Section 2 of ch. 663 provides that the act shall take effect July 1, 1976.

§ 42H. Same — Effect on eligibility of increase in social security benefits; allowable income levels.

(a) A person may not be declared ineligible under the State medical assistance program solely because social security benefits received by him have been increased unless he is deemed ineligible as a result of such increase under applicable regulations of the United States Department of Health, Education and Welfare and federal matching funds for the State Medicaid program with respect to that person are not available.

(b) This section is effective only to the extent that the provisions do not conflict with federal requirements for the administration of the program in the State.

(c) Each year, for the purpose of determining eligibility under the State medical assistance program, the Department of Health and Mental Hygiene shall set the allowable income levels in amounts at least equal to the following:

(1) Family of one — $2,300 per year

(2) Family of two — $2,800 per year

(3) Family of three — $3,300 per year

(4) Family of four — $3,800 per year

(5) Family of five or more — a proportional increase of $500 per year for each additional family member. (1977, ch. 190, § 2; 1978, ch. 427.)

Effect of amendment. — The 1978 amendment, effective July 1, 1978, added subsection (c).

Editor's note. — Section 3, ch. 190, Acts 1977, provides that the act shall take effect July 1, 1977.

Exhibit 3

STATE OF MARYLAND – MEDICAL CARE PROGRAMS

NOTICE OF POTENTIAL
RECOVERY OF MA PAYMENTS

TO: Medical Assistance Recoveries
P.O. Box 13045
Baltimore, Maryland 21203

Recipient's Name: MA #: _____
Soc. Sec. #: _____

LAST FIRST MIDDLE

Recipient's Representative: Telephone #: _____

LAST FIRST MIDDLE

Home Address:

NO. STREET BOX OR ROUTE NO.

CITY OR TOWN ZIP CODE

Home Address:

NO. STREET BOX OR ROUTE NO.

CITY OR TOWN ZIP CODE

Reason For Notice:

☐ Death: Date _____ City or County _____

☐ Voluntary: Overscale Assets: _____

☐ Third Party Action _____

☐ Other _____ (Specify)

Assets as Listed on Application:

PROPERTY DESCRIPTION LOCATION APPROXIMATE VALUE

BANK OR SAVINGS ACCOUNT INSTITUTION - ADDRESS ACCOUNT NO. AMOUNT

LIFE INSURANCE COMPANY ADDRESS VALUE

STOCKS – BONDS NAME OF COMPANY DATE OF ISSUE NO. OF SHARES

E BONDS

Third Party Action:

ACCIDENT INSURANCE

MEDICAL INSURANCE

WORKMAN'S COMPENSATION

NON SUPPORT CASE HUSBAND or FATHER'S NAME ADDRESS ZIP CODE TELEPHONE NO.

CHILD'S NAME DATE OF BIRTH

Location of Recipient
If Other Than Home: _____

COMMENTS:

LOCAL DEPT. OF SOCIAL SERVICES WORKER TELEPHONE NO.

DHMH - 1169 (5/75)

at time of death, who meets the Federal estate requirements (no spouse, no child under 21, or no blind or disabled child). The $1,200 figure is derived from the burial allowance protected under Maryland law from all claimants. In those cases where the LDSS is not sure if a claim by Medical Assistance is appropriate, Form 1169 is sent to DMAR with a note in the "Comments" section of the form indicating LDSS's lack of complete information.

Upon receipt of Form 1169 from the LDSS, DMAR sends a form letter (Exhibit 4) to the recipient's listed representative inquiring as to the disposition of the recipient's assets. This step is taken to eliminate those cases in which the recipient's assets would not be subject to probate and, consequently, would not require the opening of an estate. Assets not subject to probate include such things as jointly held bank accounts and property held as a life estate. In all cases where a representative notifies DMAR that a recipient's assets are not subject to probate, verification is asked for. This verification, consisting of copies of deeds or bank books, etc., is required before a case is closed.

A response from the recipient's representative indicating that the recipient's assets are subject to probate, initiates the preparation of a claim. All payments made by Medical Assistance on the recipient's behalf for services rendered after the recipient's 65th birthday, are researched and included in an itemization. While this research is being done, DMAR notifies the representative of its interest in the recipient's assets and of its intention to file a claim against those assets. The representative is advised that an estate must be opened to handle the recipient's assets and/or that Medicaid's claim must be paid. The representative has the option of either paying DMAR's claim or formally opening an estate.

In a majority of cases, the representative opens an estate and DMAR files a claim. The claim, consisting of a cover letter, a claim form and an itemization (Exhibits 5,6, and 7) is sent to the Register of Wills for the county in which the estate is opened, with a copy going to the estate's Personal Representative. (In Maryland, the Register of Wills office is an adjunct of the probate court for each of the State's subdivisions. The Register's office receives and "registers" all wills, estates, and claims submitted to the court. Day to day supervision of all estate matters reside with the individual Registers.) The claim is placed on a six month review system based on the date the estate is closed to creditors. Based on Maryland law, if DMAR's claim is not paid after six months, a petition can be filed with the probate court demanding payment. This petition results in action by the probate court to insure payment of DMAR's claim.

Exhibit 4

MEDICAL ASSISTANCE COMPLIANCE ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • Area Code 301 • 383-2937

Charles R. Buck, Jr., Sc.D., Secretary

RE:

Dear

The State of Maryland, through the Maryland Medical Assistance Program, has paid the medical expenses of the captioned recipient. Consequently, we are interested in the disposition of his/her assets:

Please contact me as soon as possible so that this matter may be resolved.

Very truly yours,

MAR-105

Exhibit 5

MEDICAL ASSISTANCE COMPLIANCE ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • AREA CODE 301 • 383 2937

Neil Solomon, M.D., Ph.D., Secretary

RE:

Dear

Enclosed please find a duly executed claim for filing in the captioned estate.

A copy of this claim is being sent to the Personal Representative(s):

Very truly yours,

enclosures
CC:

MAR-201

Exhibit 6

State of Maryland

CLAIM AGAINST ESTATE OF DECEDENT

The State of Maryland, pursuant to Article 43 Section 42 G of the Annotated Code of Maryland, certifies that there is due and owing by _____, deceased, in accordance with the state of account attached, as a part of this statement the sum of _____, and that the account is correct as stated and is unpaid.

On behalf of the State of Maryland, I do solemnly declare and affirm under the penalties of perjury that the information and representations made in the claim and the aforesaid account are true and correct according to my knowledge, information and belief.

Date _____ _____

This claim should be differentiated from any that may be filed by the Division of Reimbursements of the Department of Health and Mental Hygiene regarding state hospital patients.

Exhibit 7

Medical Assistance Compliance Administration
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 W. Preston Street
Baltimore, Maryland 21201

STATEMENT OF ACCOUNT
MEDICAL ASSISTANCE RECOVERIES

Date _____

MEDICAL ASSISTANCE RECIPIENT _____

MEDICAL ASSISTANCE NUMBER _____

The Form 1169 system has worked well for those cases in which the LDSS is aware of the death of a recipient. In those cases where this information is not known, DMAR loses an important notification source, which provides not only information on a recipient's death, but also detailed information concerning the recipient's assets. A computer system was developed to prevent this loss.

The system is based on a monthly match of a listing of all deaths occurring in Maryland, as reported to the State's Division of Vital Records, with Medicaid's master eligibility file. The output produced from this match is a listing of those individuals appearing in both records who are not shown as deceased on the master file. This listing contains those recipients whom Medicaid and, consequently, LDSS did not know were deceased.

The listing is divided by subdivision and sent to the appropriate LDSS. The LDSS verifies, through information in their case records, those individuals on the list who are, in fact, recipients. For the identified recipients, the LDSS sends a Form 1169 to DMAR and, via on-line terminal, changes the recipient's status to "Deceased". This system results in additional Form 1169 estate referrals to DMAR and updates Maryland's master file to reflect the most current recipient information possible.

In some cases, DMAR is notified of the death of a recipient who has neither friends nor relatives willing to open an estate. If research reveals sufficient assets at the time of death to warrant such action, DMAR, as a creditor, opens an estate for the recipient. DMAR's attorney submits an application to the Register of Wills and is named the estate's personal representative. A claim is filed by DMAR in the same manner as in any other estate. Although opening the estate for the benefit of the Medicaid program, DMAR's attorney is primarily responsible to the court for the judicious handling of the recipient's assets in accordance with general probate laws and procedures.

The second major notification system is based on a listing of opened estates provided to DMAR by the Register of Wills offices. These listings, which are provided to a number of State agencies for various purposes, list all estates opened in a particular county for a given month. The listings include the name of the decedent, the name of the estate's personal representative, the date the estate was opened, and the type of estate (Small or Formal). In lieu of this listing, some counties send copies of the actual document (Exhibit 8) by which an estate is officially opened. This document, which is required for all estates, contains the same information as the estate listings.

Upon receipt of these listings (or documents), each decedent is checked via on-line terminal against Maryland's master eligibility file. For all matches or near matches, a form letter (Exhibit 9) is sent to the listed personal representative of the estate asking for information to verify the identity of the deceased and to determine the appropriateness of filing a claim. A claim is filed or the notice is discarded depending on the information received from the personal representative. In those cases where the personal representative ignores DMAR's request for information or refuses to provide the requested information, a claim is submitted. The claim is accompanied by a form letter (Exhibit 10) asking for the same information as the previous letter. Additionally, this letter advises the personal representative that the claim would be withdrawn if information provided warranted such action.

In those cases where notification is received concerning an estate which will close to credits within thirty days, research is done and a claim is submitted accompanied by the form letter described above. This is done to insure that the State's claim is protected and is not barred by any filing deadlines. When the information requested is received from the personal representative, a decision is made to either waive the claim or let it stand.

If you want to get into the area of estate collections, you must create a firm legal base in your individual States. Maryland's legislation is a very simple bill, saying that in accordance with Federal limitations, the State of

Exhibit 8

TO BE FILED IN DUPLICATE

_____ESQ.

_____

_____

NOTICE OF APPOINTMENT
and
NOTICE TO CREDITORS
and
NOTICE TO UNKNOWN HEIRS

TO ALL PERSONS INTERESTED IN THE ESTATE OF

_____

This is to give notice that the undersigned,

_____ whose address is

_____

was, on _____ appointed personal representative of the estate of

_____ who died on _____,

(with) a will.

Notice is also given to unknown heirs at law and to heirs whose whereabouts are unknown to cause their appearance to be entered in this proceeding.

All persons having any objection to the appointment (or to the probate of the decedent's will) shall file the same with the Register of Wills for _____ county, on or before the _____ day of _____, 19____.

All persons having claims against the decedent must present their claims to the undersigned, or with the Register of Wills' office, with a copy to the undersigned personal representative, on or before the _____ day of _____, 19____.

Any claim not filed on or before that date, or any extension provided by law, is enforceable thereafter.

_____

_____

_____

Personal Representative

Exhibit 9

MEDICAL ASSISTANCE COMPLIANCE ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • AREA CODE 301 • 383-2937

Neil Solomon, M.D., Ph.D., Secretary

RE:

Dear

We have been informed that you are involved in settling the estate of the individual named above. Our records indicate that the deceased (or a person with the same name) was receiving Medical Assistance through the State of Maryland. However, we need the following information in order to confirm this:

1) Under which Social Security # was the decedent receiving benefits, if any?_____

2) What was the address of the decedent?_____

3) What was the month and year of the decedent's birth?_____

Please supply us with the information requested below in order for us to determine whether a claim for reimbursement should be filed, and return this letter as soon as possible in the enclosed, self-addressed envelope.

1) Is decedent survived by a husband/wife? If so, please give name.

2) List name, address, and age of all children of the decedent. Please indicate if any are handicapped or disabled.

If we do not receive the above information within a reasonable period of time, a claim will be filed against the decedent's estate to protect the State's interest. If a claim is to be filed, we will contact you by mail within several weeks after this letter is returned to us.

Sincerely,

Richard Burkhardt,
Recoveries Officer
Medical Assistance Recoveries

DHMH 1160

Exhibit 10

MEDICAL ASSISTANCE COMPLIANCE ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • AREA CODE 301 • 383-2037

Charles R. Buck, Jr., Sc.D., Secretary

RE:

Dear

We have been informed that you are involved in settling the estate of the individual named above. Our records indicate that the deceased (or a person with the same name) was receiving Medical Assistance through the State of Maryland. However, we need the following information in order to confirm this:

1). Under which Social Security # was the decedent receiving benefits, if any?_____

2) What was the address of the decedent?_____

_____

3) What was the month and year of the decedent's birth?_____

The Program has the authority to withdraw the claim under certain circumstances. Please supply us with the information requested below in order for us to determine whether our claim for reimbursement should remain as filed. The requested information will allow us to reach a decision. Return this letter as soon as possible in the enclosed, self-addressed envelope.

1) Is decedent survived by a husband/wife? If so, please give name.

_____

2) List name, address, and age of all children of the decedent. Please indicate if any are handicapped or disabled.

_____

_____

_____

Sincerely,

Richard Burkhardt,
Recoveries Officer
Medical Assistance Recoveries

RB:pnw

Maryland will have a right to file claims against the estates of the deceased recipients. The only adjustment we made in writing the bill was to allow some discretion as to when claims will and will not be filed. We added a statement that in case of substantial hardship, we do have the authority to waive our claim. We did this to cover the situation where an elderly brother and sister were living together and wanted to keep medical assistance and the one who dies has title to property. Under strict interpretation of the law, we would have to go after that piece of property; we don't want to have to do that. We want to have some discretion as to whether or not we are going to file the claim.

Your next major problem in developing the system is to develop procedures to notify you when the cases are being opened.

The system works very well with a minimum of effort involved. The only problem we found with the system, based on the local department, is that very often they are unaware of the death of the recipient. For some categories in Maryland, recipients in the past were certified a year at a time and it was possible no one would know of the death of one of the recipients for a considerable length of time. This caused the problem of us being notified after the estate had already been opened and closed. Maryland is going to a six month certification so that problem should be ended for the most part.

Question: Do you have any idea of what the potential might be in a categorically needy State?

Answer: I would think it would be similar. Because the main asset that you recover from the estate is the home property which is not considered as part of the estate for eligibility purposes. That's always intact and that's the main source of recovery as far as the State is concerned. You very seldom find a recipient with any liquid assets. What you are going after is the home property.

Question: Where there is a homestead and a surviving spouse, not having a client, how do you track it before the death of the surviving spouse?

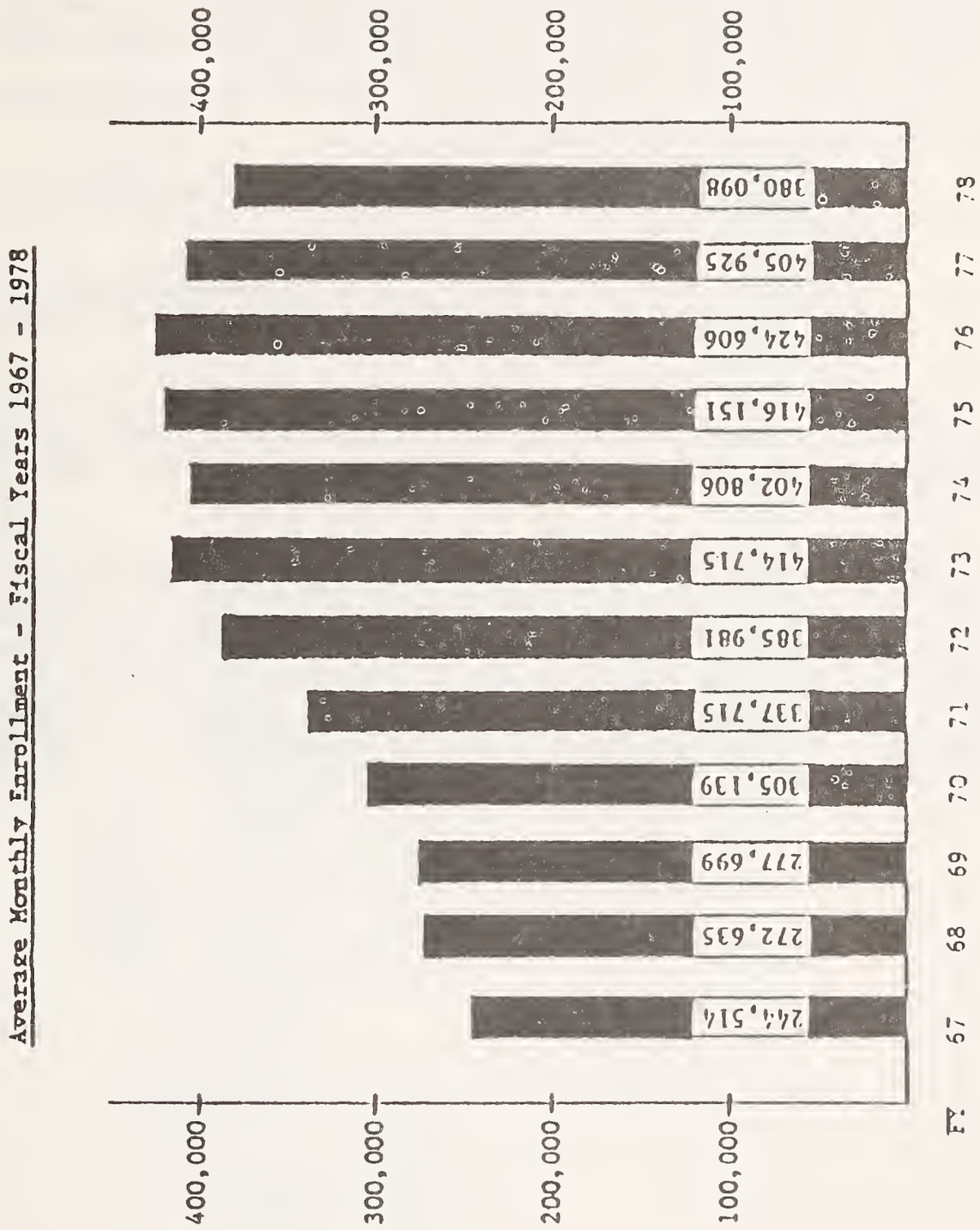
Answer: We don't.

Question: Suppose the estate does not cover all of the claims. You have a $10,000 estate and $40,000 worth of claims against it, including medical assistance. Who gets priority?

Answer: Under Maryland State law, there are a list of priority claimants from taxes, commissions, fees and so forth. We are just a general creditor. Under Maryland law, if we wanted to be a priority claimant we would have to restrict that claim to three years prior to the date of death which would be no advantage to us. You find that very seldom with the recipient. You have a claim from another source.

Staffing necessary for an estate recovery system is dependent, obviously on a particular State's Medicaid population. Maryland's Medicaid population has averaged 405,000 recipients over the past five fiscal years ('74 - '78) (Exhibit 11). With this population, two positions have been assigned full time to estate collections (1 professional, 1 clerical). These positions have been more than adequate to handle the caseload.

Exhibit 11


Average Monthly Enrollment - Fiscal Years 1967 - 1978
400,000
300,000
200,000
100,000
244,514
272,635
277,699
305,139
337,715
385,981
414,715
402,806
416,151
424,606
405,925
380,098
FY
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The professional employee whose yearly salary is $12,767, determines the course of development for each case; handles all contact with the LDSS's, the Register of Wills and the recipients' representatives; and insures all systems and procedures are working efficiently and effectively. The clerical position, whose salary is $8,485, in addition to providing normal support, handles aspects of research concerning amounts paid by the program on the recipient's behalf. Support is provided to these positions by an attorney who is available for those situations in which a claim filed by DMAR is disputed and must be defended before a probate court, and whenever DMAR decides to open an estate. Additionally, a general research person is available to perform eligibility and payment research to establish and support DMAR claims.

To recap, a State Medicaid agency, initiating the development of an estate recovery system must begin by:

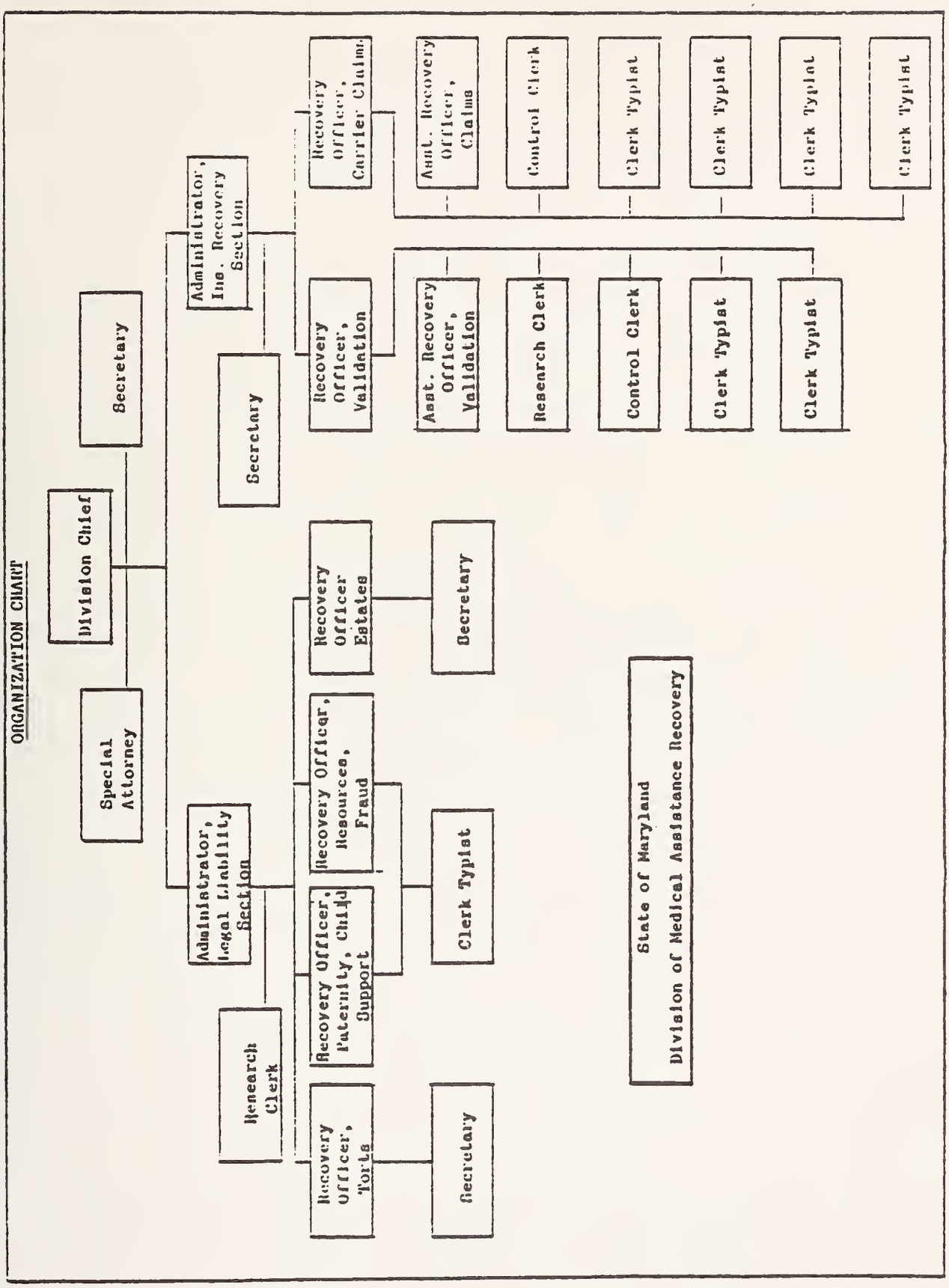
1. Establishing clear legal authority for the effort based on Federal regulation.

2. Developing notification procedures for potential estates centering on those agencies involved in eligibility determination and/or the handling of probate matters.

The estate area is ideal for those States without large scale recovery programs who are looking for ways to gain experience in the field and, at the same time, a means to justify increased resources for more ambitious collection efforts.

DMAR has grown significantly since it began probate recoveries in 1971. The division (Exhibit 12) is involved in every area of Medicaid recovery activity. It is estimated that FY 1979 collections from these activities will be over $3 million. With the full operation of the Division's insurance system, FY 1980 collections are projected at over $6 million. Despite this overall growth, probate collections are still considered a valuable source of collections. With a cost/benefit ratio of approximately 1 to 20, its contribution to Maryland's recovery effort is quite apparent.

Exhibit 12


ORGANIZATION CHART
Division Chief
Secretary
Special Attorney
Administrator, Legal Liability Section
Research Clerk
Recovery Officer, Torts
Secretary
Recovery Officer, Paternity, Child Support
Recovery Officer, Resources, Fraud
Clerk Typist
Recovery Officer Estates
Secretary
Administrator, Ins. Recovery Section
Secretary
Recovery Officer, Validation
Asst. Recovery Officer, Validation
Research Clerk
Control Clerk
Clerk Typist
Clerk Typist
Recovery Officer, Carrier Claims
Asst. Recovery Officer, Claims
Control Clerk
Clerk Typist
Clerk Typist
Clerk Typist
Clerk Typist
State of Maryland
Division of Medical Assistance Recovery

ACCOUNTING AND FINANCE

Michael Clurman

Medical/Economics Specialist

Systems Architects, Inc.

This talk will concern a tracking and accounts receivable system to track claims for which benefit recovery is being pursued and to keep an up to date accounting of monies received and monies being claimed from liable third parties. This work is based on some work that CAPD and SAI did for the State of Illinois in developing such a system. It is hoped that something along these lines could, perhaps, be the basis for a seventh volume of blue books about the MMIS system.

The first two objectives of the tracking and accounts receivable system are really data base characteristics. You want to date and document all significant events from the time when a claim is identified as one for which benefit recovery is to be pursued, until the time that the effort to recover benefits ends, and the record is moved to the claims history file. This includes all actions taken by the department: all documents sent out, all documents received and those payments sent out, all documents received and those payments received with the dates for each event. Of course, part of this data base, an integral part of the record, as well as changes in claims status, is an up to date financial account. An up to date financial account means an account of the invoice coming in from the provider, an account of the money paid by the department to the provider, and an account of all payments received from the third party, with dates attached to every one of those events. Those first two are characteristics of the data base record. The next two of those are management reporting objectives of the system. That is, the data base should be designed to produce management reports that will report on the breakdown of the amounts recovered by the specific case characteristics.

To take a simple example, a State may be very interested in finding out the amount recovered by insurance carriers with whom the recoveries are being pursued. A management report along those lines may well help to identify carriers who present special problems in recovering benefits. There are many other possible case characteristics, especially in the casualty area, which we will get into later. Breaking down amounts covered by specific case characteristics in addition to identifying problems with particular insurance carriers will also help the department identify the cases which will be the most productive to pursue. That is an important management objective and it is an important type of management report to pursue.

Finally, we reach the last of those five items. To produce operational documents -- that is really sort of a third category. The first two are data base characteristics, the second two are management report objectives, and the final one is to produce operational documents designed to facilitate the benefit recovery process. That includes claim forms to the carriers, followup letters, and letters reminding them that they have been tardy in replying. Important operational documents are internal notices and case status reports for the TPL unit itself, notifying them of particularly long casualty cases, if there is a case pending, what its current status is and what actions have to be taken on that case.

The system output amplifies those points. All those items are things that the system is capable of telling us. The date that any payment was received or dates that any document is sent out.

Next, the management reporting objectives of the tracking and accounts receivable system. One of the management reporting objectives is to really isolate and identify the factors affecting recovery claims. I mentioned before the particular insurance carrier who is billed. In addition, if some counties might be picking up less client data than others, it might be the county where the client was registered has a less successful client intake system.

In the casualty area, there are many different factors which we might look at which affect recovery claims, such as trauma code, type of accident, or existence of casualty insurance. I'll mention some of those in more detail a little later. One of the key management reporting objectives is what characteristics of cases seem to affect the recovery time. I am not only interested in amounts, but if a particular type of casualty case seems to typically be stretched out over five years, even though a lot of money is collected, it might be somewhat less productive than a different type of case, which takes on the average two months to collect. A case aging report where the case age is broken down by characteristics of the case might be a very effective management tool.

The core of the record relating to each particular claim for which benefits are being pursued is going to be the accounts receivable information. It won't be the only information on it, but it is certainly the core information. We record all payments received and things of that sort. Also, in the particular case of Illinois, just to illustrate how you can fit in special State characteristics or program characteristics of a system like this, I will discuss the special provisions that were made in their tracking system for stays of over thirty days. I don't know how many other States have the same set up, but in Illinois providers were encouraged to bill the Title XIX agency on a bill that was net of an estimated insurance carrier liability. Then, when a payment was actually received by the provider from the insurance carrier, the documentation concerning that payment to the department would be a reconciliation. In other words, if the insurance company paid more than had been estimated, the excess would be subtracted from the amount paid the provider. Then, the provider would owe the State some money. If the carrier paid less, the provider would get a supplemental payment from the State. So you would have a slightly different type of accounts receivable record for invoices that came in with an estimated insurance carrier liability on them. This would have to be a record where there is a data item for the actual insurance company payment which was paid and then reconciled, emphasizing the role of a tracking and accounts receivable system in producing operating documents of various kinds.

I will start with the last one, which is the most obscure, because it relates to the estimated insurance liability which I just mentioned. One kind of operating document that a system like this could be programmed to produce would be when the providers send in to the department the documentation on the actual insurance company payment. The computer would be programmed to send out a form. The form would either be a request for a refund from the excess of Medicaid payments to the provider, or the form to accompany an additional supplemental payment by the Medicaid agency to the provider. Just indicating that process could be automated. I'm sure in particular State systems there are lots of processes like that, that could be profitably automated.

More prosaic operating documents that would be produced include a benefit recovery claim that would just go out to the insurance carrier, with all the information on the type of illness, payment made, and that information necessary for the carrier to adjudicate the claim. Then letters to the carrier, reminder letters to lawyers, casualty insurance companies or the Attorney General's office. All of those things could not be automated, but some of them could. Finally, a very important kind of operating document in a lengthy casualty case would be periodic case data status sheets for the use of agency personnel, that would come out at regular intervals. Also, if there are changes in case status that generally will call for action on the part of the department, so a complicated casualty case doesn't get lost, the system should be programmed to indicate a change in status at the point when the input information is received. It would automatically put out a special case data status report with a list of recommended or possible actions that the department could take.

Overall, the thing is designed to try to insure that a complicated casualty case just does not fall between the cracks in the long time that transpires between the time it is first identified and the time it is finally settled.

Of course the tracking system is designed with an automatic data processing system in mind. It is designed to be a large scale data base with records that could, depending on how complicated it was going to be, have a lot of individual data items. It will only work with an automated data processing system, and ideally it will allow some kind of on-line, very rapid access to current case data, so in addition to periodic case data status report, you want to have the capability to have a worker punch in a request for information, accounts receivable information, case data status information, everything that has transpired in that case since day one, and to get a report out on the CRT. So those are required in an automated data processing system.

The work flow through a health insurance tracking system and a casualty insurance tracking system starts with a point that an invoice is flagged for benefit recovery. It is identified as one which benefits can be recovered from the third party. In the case of Illinois there was a decision box whether there was an estimated invoice or whether it was a normal invoice. If it's a normal invoice, there is another decision box asking whether the carrier will be billed automatically. I think many States would go along with the idea that initially, when you have an automated system in place, you want a very high percentage, if not all of your claims, to go through manual review before merely sending them out to insurance carriers, without benefit of intervention. Initially, most claims would not be sent out automatically; only after confidence is gained in the system would an increasing proportion be sent automatically. They are sent out automatically; if the system just produces a benefit recovery claim form, it produces addressing labels to the carrier and updates the data base. If they're not produced automatically, the computer produces a data sheet, summarizing all the data that human beings intervening in the process will need in order to make a decision. The human beings will make their decision, recovery action to be pursued if they decide to recover, then the claim form will be mailed out. If not, the data base will be updated with a recent code indicating the reason why you decided not to pursue benefit recovery, and the record will use claim history.

If it was an estimated invoice, where the provider mailed in a bill that was net of an estimated amount of payment from an insurance carrier, then after payment is made of that estimated bill by the State, the State would next receive notification from the provider along with appropriate documentation of the receipt of an actual payment amount from the carrier. The data base would be updated with that information, there would be a reconciliation of the actual versus estimated carrier payment, and a notice would be sent to the provider telling him/her that either we owe you an additional payment, or you owe us a refund. Within a specified period of time, maybe six months, accounts between the State and the particular provider will be balanced on a batch basis.

All the reports I titled and discussed are custom made reports designed for State management personnel. It's understood that a system like the accounts receivable system has to produce the information for the 64.9a. It's going to do it from the accounts receivable information in the data base. What I would like to do here is discuss some of the potential of such a system providing information that State program managers can use as a basis for defining their systems.

Characteristics of casualty cases can be used to find out how much is being collected through the six characteristics identified. We should break down how long it takes to collect money, and how much has been collected. We want to know if a lot is being collected from a subset of cases with a particular type of diagnostic codes. We want to know if a lot is being collected from auto no-fault insurance or worker's compensation. We also want to know any particular types of accidents which lead to claims which take a long time to collect on. We want both amounts and aging broken down by those case characteristics. We also thought that would be a valuable type of report for any management trying to devise sensible guidelines for a productive casualty recovery system, so they can quickly identify those cases where the maximum resources will be poured in. They can ignore those cases which either prove very unproductive or have taken a long time to produce any results. Another type of report, since all system events will be dated in this data base, we might just break down the causes for delay in actually getting claim money returned, like how much time each of these causes actually creates a delay. So those are two different types of reports that might help management in: a) pinpointing causes for delay, and breaking those bottlenecks, and b) figuring out the most productive types of casualty cases to pursue.

One of the reasons why that kind of thing has developed is, through the inquiry of SAI, I know that in California, we really couldn't give them that information. We know that we would like to have it, but we could not give it. If you are going to make learned decisions on how to use your limited resources, that is very nice information to have. So as your systems design is working, think about those kinds of areas, the kinds of things you want built into systems design. Perhaps you can afford to get that information time-wise, perhaps you can't.

Some characteristics of case aging reports. Case aging reports might be broken down on the basis of insurance carrier. You might want to know those carriers that take an awfully long time to return money, and pinpoint them quickly. You might want to know counties, if there was some doubt about

whether some county was producing TPL data as well as other counties. You might want to see if other counties took longer to get recoveries than others, or find out who is on agency rolls.

To conclude, a benefit recovery and accounts receivable system is going to date and track all system events from the time the case is first flagged, to the time the case is closed. Its primary objectives are going to be updated accounts receivable information, production of operating documents, notices and letters needed by the department to facilitate the benefit recovery process, and the production of management reports which will facilitate agency management decision making. And we might add the fourth objective of producing those Federal reports required which is also important.

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